Volume 39, Number 1
Pages 1–186
January 2, 2014

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JASON KANDER

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

JASON KANDER

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

DIRECTOR

WAYLENE W. HILES

•

MANAGING EDITOR

CURTIS W. TREAT

•

EDITOR

ABBEY RIMEL

•

ASSOCIATE EDITOR

AMANDA MCKAY

•

PUBLICATION TECHNICIAN

JACQUELINE D. WHITE

•

ADMINISTRATIVE ASSISTANT

ALISHA DUDENHOEFFER

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO

Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER

Office of the Secretary of State

Administrative Rules Division

PO Box 1767

Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is http://www.sos.mo.gov/adrules/moreg/moreg.asp and the CSR is http://www.sos.mo.gov/adrules/csr/csr.asp. These websites contain rulemakings and regulations as they appear in the Registers and CSR. These websites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo Supp. 2013. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

January 2, 2014

Vol. 39 No. 1 **Pages 1–186**

IN THIS ISSUE:

EMERGENCY RULES

Missouri Consolidated Health Care Plan
Health Care Plan 5

PROPOSED RULES

Department of Agriculture
Animal Health 68
Department of Insurance, Financial Institutions and Professional Registration
Board of Cosmetology and Barber Examiners 68
State Board of Optometry 73
Missouri Consolidated Health Care Plan
Health Care Plan 73

ORDERS OF RULEMAKING

Department of Economic Development
Public Service Commission 149
Department of Natural Resources
Petroleum and Hazardous Substance Storage Tanks 150
Department of Public Safety
Office of the Director 162
Peace Officer Standards and Training Program 163
Department of Revenue
Director of Revenue 163
Department of Social Services
Family Support Division 164
Elected Officials
Secretary of State 166

IN ADDITIONS

Department of Health and Senior Services
Missouri Health Facilities Review Committee 167
Department of Insurance, Financial Institutions and Professional Registration
Construction Claims Binding Arbitration Cap 167
Sovereign Immunity Limits 167
State Legal Expense Fund Cap 167

CONTRACTOR DEBARMENT LIST 168

DISSOLUTIONS 169

SOURCE GUIDES

RULE CHANGES SINCE UPDATE 170
EMERGENCY RULES IN EFFECT 176
EXECUTIVE ORDERS 178
REGISTER INDEX 179

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
September 3, 2013	**October 1, 2013**	October 31, 2013	November 30, 2013
September 16, 2013	**October 15, 2013**	October 31, 2013	November 30, 2013
October 1, 2013	**November 1, 2013**	November 30, 2013	December 30, 2013
October 15, 2013	**November 15, 2013**	November 30, 2013	December 30, 2013
November 1, 2013	**December 2, 2013**	December 31, 2013	January 30, 2014
November 15, 2013	**December 16, 2013**	December 31, 2013	January 30, 2014
December 2, 2013	**January 2, 2014**	January 29, 2014	February 28, 2014
December 16, 2013	**January 15, 2014**	January 29, 2014	February 28, 2014
January 2, 2014	**February 3, 2014**	February 28, 2014	March 30, 2014
January 15, 2014	**February 18, 2014**	February 28, 2014	March 30, 2014
February 3, 2014	**March 3, 2014**	March 31, 2014	April 30, 2014
February 18, 2014	**March 17, 2014**	March 31, 2014	April 30, 2014
March 3, 2014	**April 1, 2014**	April 30, 2014	May 30, 2014
March 17, 2014	**April 15, 2014**	April 30, 2014	May 30, 2014
April 1, 2014	**May 1, 2014**	May 31, 2014	June 30, 2014
April 15, 2014	**May 15, 2014**	May 31, 2014	June 30, 2014
May 1, 2014	**June 2, 2014**	June 30, 2014	July 30, 2014
May 15, 2014	**June 16, 2014**	June 30, 2014	July 30, 2014

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

Missouri Participating Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Documents Law (section 181.100, RSMo Supp. 2013), are available in the listed participating libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951 ext. 160

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2742

Eden/Webster Library
Eden Theological Seminary/
Webster University
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660 ext. 7812

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University Law Library
Washington University
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6443

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300 ext. 247

Library
Maryville University
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

Pickler Memorial Library
Truman State University
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 1997 E. Jackson Blvd.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

James C. Kirkpatrick Library
University of Central Missouri
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
14 West 10th Street
Kansas City, MO 64105
(816) 701-3546

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

Miller Nichols Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

St. Joseph Public Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Hearnes Learning Resources Ctr.
Missouri Western State University
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948 ext. 325

Spiva Library
Missouri Southern State University
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9342

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3615

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
106 B Ellis Library
Columbia, MO 65211-5149
(573) 882-0748

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65211-7298
(573) 882-9369

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161 ext. 359

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Smiley Memorial Library
Central Methodist University
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6279

Library
Missouri University of Science and
Technology
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Lebanon-Laclede County Library
915 S. Jefferson Ave.
Lebanon, MO 65536-3017
(417) 532-2148

University Library
Southwest Baptist University
1600 University Ave.
Bolivar, MO 65613-2597
(417) 328-1631

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411 ext. 3551

Garnett Library
Missouri State University—West
Plains
304 Cleveland
West Plains, MO 65775-3414
(417) 255-7945

Springfield-Greene County Library
4653 S. Campbell
Springfield, MO 65801-0760
(417) 874-8110

Meyer Library
Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is adding section (44); amending sections (27), (42), and (49); and renumbering as necessary.

PURPOSE: This amendment revises the term chemical dependency to substance use disorder, revises the definition of medically necessary, and adds the definition of Medicare Prescription Drug Plan (PDP).

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(27) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/*[chemical dependency]* **substance abuse disorder** office visits;

(42) Medically necessary. **The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary** *[T]***t**reatments, procedures, services, or supplies that the plan administrator **or its designee** determines, in the exercise of its discretion **are**—

(A) *[Are e]***E**xpected to be of clear clinical benefit to the *[patient]* **member**; *[and]*

(B) *[Are appropriate for the care and treatment of the injury or illness in question; and]* **Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;**

(C) *[Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.]* **In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;**

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

(44) Medicare Prescription Drug Plan (PDP). The Medicare Prescription Drug Plan, administered by Express Scripts Medicare PDP is a Medicare Part D Plan with additional coverage to ensure Medicare members have similar benefits to non-Medicare members.

*[(44)]***(45)** Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

*[(45)]***(46)** Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

*[(46)]***(47)** Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

*[(47)]***(48)** Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

*[(48)]***(49)** Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.

*[(49)]***(50)** Participant. Shall have the same meaning as the term member defined herein (see member, section *[(44)]***(45)**.

*[(50)]***(51)** Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(51)]***(52)** Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

*[(52)]***(53)** Plan year. The period of January 1 through December 31.

*[(53)]***(54)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

*[(54)]***(55)** Premium. The monthly amount that must be paid for health insurance.

*[(55)]***(56)** Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

*[(56)]***(57)** Prior authorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.

*[(57)]***(58)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(19). Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

*[(58)]***(59)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(59)]***(60)** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

*[(60)]***(61)** Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.

*[(61)]***(62)** Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(62)]***(63)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(63)]***(64)** Specialty medications. High-cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(64)]***(65)** State. Missouri.

*[(65)]***(66)** Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(66)]***(67)** Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

*[(67)]***(68)** Subscriber. The employee or member who elects coverage under the plan.

*[(68)]***(69)** Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

*[(69)]***(70)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

*[(70)]***(71)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(71)]***(72)** Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

*[(72)]***(73)** Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

*[(73)]***(74)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(74)]***(75)** Vend**o**r. The current applicable third-party administrators of MCHCP benefits.

*[(75)]***(76)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), (8), (9), (10), and (12).

PURPOSE: This amendment revises language regarding the deadline for election of coverage for survivors, eligibility for new enrollments of disabled children over the age of twenty-six (26) years, leave of absence direct bill, transfer of coverage and reenrollment, and the time period COBRA disabled members may continue coverage; adds language regarding enrollment policy for employees, retirees, terminated vested subscribers, long-term disability subscribers and survivors who do not complete enrollment during the open enrollment period, the timeframe for reinstating medical coverage after a voluntary cancelation, claims processing for Medicare members and requirements for members to notify MCHCP of Medicare coverage; and removes language regarding the review of MCHCP's prescription drug plan and language regarding member enrollment in a Medicare Part D plan in addition to coverage under MCHCP because they are no longer applicable.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. A retiree who returns to state employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

6. *[If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.]* **An employee who is eligible to continue coverage as a retiree must submit the Retiree Enrollment form at least thirty (30) days prior to the effective date of retirement.**

A. If the Retiree Enrollment form is not submitted thirty (30) days prior to the effective date of retirement the employee they shall not thereafter be eligible for coverage.

(C) Survivor Coverage.

1. At the time of the subscriber's death, a survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits from MOSERS or PSRS and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to subscriber's death. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. A survivor of a retiree or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the subscriber's death.

3. If a survivor adds a new spouse to his/her coverage and the survivor subsequently dies, the new spouse is no longer eligible for coverage.

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days *[of their eligibility date, they shall not thereafter be eligible for coverage]* **after the first day of the month following the death of the employee, s/he cannot enroll at a later date**.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a dependent, the active employee may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

4. If an employee is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the employee is currently enrolled in, effective the first day of the next calendar year.

A. If an employee is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If an employee is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

5. If an employee is currently enrolled in dental and/or vision coverage and does not complete open enrollment **to cancel coverage or change the current level of coverage** during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days with proof of prior medical coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the retiree is currently enrolled in, effective the first day of the next calendar year.

A. If a retiree is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a retiree is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will

be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

C. If a retiree is currently enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.

6. If a retiree is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a terminated vested subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a terminated vested subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a terminated vested subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a long-term disability subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a long-term disability subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a long-term disability subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor must submit a *[s]*Survivor *[e]*Enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the survivor is currently enrolled in, effective the first day of the next calendar year.

A. If a survivor is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a survivor is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

5. If a survivor is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received.

(B) Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption listing subscriber as adoptive parent
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Government-issued death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, length of coverage, reason for coverage termination, and list of dependents covered
TRICARE Supplemental Coverage	Military ID Card
[Medicare]	*[Medicare Card]*

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled dependent or a currently enrolled permanently disabled dependent turning age twenty-six (26) **years** may continue coverage beyond age twenty-six (26) **years**, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the currently enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled dependent:

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26) **years**. Evidence could be from the Social Security Administration, representation from the dependent's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the Social Security Administration (SSA) confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) **years** is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends **or will never take effect for new enrollment requests.**

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

[(H) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.]

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the subscriber notifies MCHCP to cancel coverage.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

2. A subscriber may reinstate medical coverage after a voluntary cancelation by submitting an Enroll/Change/Cancel form prior to the end of current coverage.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, **Leave of Absence Enrollment** form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within ten (10) days of the date of the letter, coverage will continue**.** *[and t]***T**he employee will be set up on direct bill **unless the employee and affected dependents are transferred to the plan in which his/her spouse is enrolled**.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is terminated effective the last day of the month in which the employee is employed.

[3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.]

*[4.]***3.** If the employee's spouse is an active employee or retiree, the employee **and any covered dependents** may transfer *[coverage under]* to the plan in which the spouse is enrolled **if the transfer is elected on the Leave of Absence Enrollment form. Transfer is effective the first of the month following the date of leave**. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

*[5.]***4.** Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage *[in]* **with** MCHCP while on leave, may *[recommence]* **reenroll in** his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. **When a leave of absence employee returns to work and MCHCP receives a state contribution for the month s/he returned, s/he will be charged the active employee premium for that month.** For coverage to be reinstated, the employee must submit a completed **Enroll/Change/Cancel** form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

*[6.]***5.** If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents who have coverage due to the death of a non-vested employee may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) own expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage **and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage**, the member may continue coverage for up to *[twenty-nine (29)]* **an additional eleven (11)** months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(12) Medicare.

[(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.]

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(C) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65) years, the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (3), (4), and (5); and adding new section (4); and renumbering as necessary.

PURPOSE: This amendment revises the MCHCP contribution methodology for members retiring prior to July 1, 2012, the billing schedule and due dates for direct bill for Medicare primary Consolidated Omnibus Budget Reconciliation Act (COBRA), long-term disability, leave of absence, terminated vested and retiree and survivor members; and adds language regarding the methodology for the MCHCP contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan and the effect on coverage for non-payment of premium for Medicare primary subscribers.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium **for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan** is based on *[creditable years of service at retirement with the state.]* **either of the following:**

(A) It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). For Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (3)(A) is compared to the flat dollar amount that was contributed for the same rate tier in 2002. The retiree's subsidy is the greater of the amount calculated in subsection (3)(A) or the flat dollar amount that was contributed in 2002.

(4) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (4)(A) is compared to fifty-two percent (52%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (4)(A) or fifty-two percent (52%) of the Medicare Prescription Drug Only Plan.

*[(4)]***(5)** Premium. Payroll deductions, Automated Clearing House (ACH) transactions, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes past-due premiums, the payroll deductions for current premiums along with the payroll deductions for past-due premiums will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars ($50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars ($51) to one hundred dollars ($100) will be deducted from two (2) payrolls;

C. One hundred one dollars ($101) to two hundred dollars ($200) will be deducted from three (3) payrolls;

D. Two hundred one dollars ($201) to three hundred dollars ($300) will be deducted from four (4) payrolls;

E. Three hundred one dollars ($301) to four hundred dollars ($400) will be deducted from five (5) payrolls;

F. Four hundred one dollars ($401) to five hundred dollars ($500) will be deducted from six (6) payrolls;

G. Five hundred one dollars ($501) to six hundred dollars ($600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars ($601) to seven hundred dollars ($700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars ($701) to eight hundred ($800) dollars will be deducted from nine (9) payrolls;

J. Eight hundred one dollars ($801) to nine hundred dollars ($900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars ($901) to one thousand dollars ($1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars ($1,001) and over will be deducted from twelve (12) payrolls.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums will be divided equally and taken from the subscriber's future payrolls as follows:

(I) One hundred dollars ($100) or less, deduction will be taken from one (1) payroll;

(II) One hundred one dollars ($101) to three hundred dollars ($300) will be deducted from two (2) payrolls;

(III) Three hundred one dollars ($301) to five hundred dollars ($500) will be deducted from three (3) payrolls;

(IV) Five hundred one dollars ($501) to seven hundred dollars ($700) will be deducted from four (4) payrolls;

(V) Seven hundred one dollars ($701) to nine hundred dollars ($900) will be deducted from five (5) payrolls; and

(VI) Nine hundred one dollars ($901) and over will be deducted from six (6) payrolls.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

2. If a retiree or survivor is currently having deductions taken from his/her benefit check and owes past-due premiums due to a change in his/her deductions, MCHCP will contact MOSERS to determine if the benefit check is large enough to cover the past-due premiums. If the benefit check is large enough to cover the past-due premiums, deductions will be divided and taken from the retiree or survivor's next three (3) benefit checks and coverage will be continuous. If the retiree or survivor's benefit check is not large enough to cover the deductions, and the retiree or survivor has failed to make the necessary premium payments, coverage will be terminated due to nonpayment, effective the last day of the month a full premium was received.

(D) Direct Bill for **non-Medicare** Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

[2. If a member is in arrears for two (2) months of premiums and payment is not received by the fifteenth of the second month for which premiums are due, coverage is terminated due to nonpayment on the last day of the month for which full premium was received. The member will be responsible for the value of the services rendered after the retroactive termination date (example: bill sent September 30 for October premiums and no payment received; bill mailed October 31 for October and November premiums due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30).]

(E) Direct Bill for Medicare Primary Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

*[(E)]***(F)** ACH Electronic Payment of Premiums for COBRA, Long-Term Disability, **Leave of Absence,** Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

2. If there are insufficient funds, MCHCP will send the *[member]* **subscriber** a letter and bill requesting payment. *[If a payment is in arrears, the direct bill timeline applies as defined in paragraph (4)(D)2.]*

*[(5)]***(6)** Premium Payments.

(A) By enrolling in coverage under MCHCP, a *[member]* **subscriber** agrees that MCHCP may deduct the member's contribution toward the total premium from the *[member's]* **subscriber's** paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending on the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the *[member's]* **subscriber's** payroll.

(B) MCHCP will automatically deduct the premium from the retiree or survivor's check. If the retiree or survivor's check is not sufficient to cover the retiree's or survivor's contribution toward total premium, the retiree or survivor will receive a monthly bill. A retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction from his/her retiree or survivor's check by contacting MCHCP.

1. If the retiree or survivor fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received.

2. If coverage terminates on the retiree, survivor, vested, or COBRA subscriber or his/her dependents, the subscriber cannot enroll in the plan at a later date. The subscriber is responsible for claims submitted after the termination date.

(C) If a *[member]* **non-Medicare subscriber** fails to pay premiums by the required due date, MCHCP allows a thirty-one- (31-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, *[the member]* **coverage** will be retroactively *[terminated to the date covered by the member's last paid premium.]* **terminated on the last day of the month for which full premium payment was received.** The *[member]* **subscriber** will be responsible for the value

of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

(D) If a Medicare Primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends.

*[(6)]***(7)** Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period ending at the end of the month preceding the month during which notice of overpayment is received by MCHCP.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending subsection (1)(A).

PURPOSE: This amendment revises language regarding prior authorization for pharmacy services, the amount of time the member is given to submit additional documentation for prior authorizations, and removes language regarding the shingles vaccine.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) **years**, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service*[. Annual dollar limit may be exceeded with prior authorization]*;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care;

N. Hospice care and palliative services;

O. Hospital inpatient services except for observation stays;

P. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

Q. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

R. Nutritional counseling after three (3) sessions annually;

S. Orthognathic surgery;

T. Orthotics over one thousand dollars ($1,000);

U. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

V. Procedures with codes ending in "T";

W. Prostheses over one thousand dollars ($1,000);

X. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Y. Skilled nursing facility;

Z. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips,

tongue, roof, and floor of the mouth when such conditions require pathological exams); and

AA. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services **included in the prescription drug plan for non-Medicare primary members** are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations;

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications; and

[G. Shingles vaccines prescribed by a physician.]

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least *[forty-five (45)]* **ninety (90)** calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (6), (7), and (8); adding new sections (5), and (11); and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, members who will have access to claim and payment information and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, out-of-pocket maximum amounts, how the subscriber is determined when both spouses are state employees, the percentage of usual, customary, and reasonable fees allowed, and timely filing of claims.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family each calendar year, one thousand two hundred dollars ($1,200).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out-of-network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(C) Network out-of-pocket maximum for individual—*[one thousand two hundred dollars ($1,200)]* **one thousand three hundred seventy-five dollars ($1,375)**.

(D) Network out-of-pocket maximum for family—*[two thousand four hundred dollars ($2,400)]* **two thousand seven hundred fifty dollars ($2,750)**.

(E) Non-network out-of-pocket maximum for individual—*[two thousand four hundred dollars ($2,400)]* **two thousand seven hundred fifty dollars ($2,750)**.

(F) Non-network out-of-pocket maximum for family—*[four thousand eight hundred dollars ($4,800)]* **five thousand five hundred**

dollars ($5,500).

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: *[copayments;]* charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed amount for transplants performed by a non-network provider.

(4) Married, active employees who are MCHCP subscribers *[need to]* **and have enrolled children may** meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. *[Each subscriber will have access to all claim and payment information of the family unit.]* **In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber.** Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

*[(6)]***(7)** Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible *[or out-of-pocket maximum]*.

(A) Office visit—primary care: twenty-five dollars ($25); specialist: forty dollars ($40); chiropractor **office visit** and/or manipulation: twenty dollars ($20); urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the *[deductable]* **deductible** and coinsurance.

1. Vision office visit or refraction: forty dollars ($40);

2. Hearing test—performed by a primary care provider: twenty-five dollars ($25); performed by a specialist: forty dollars ($40).

(B) Emergency room—two hundred dollars ($200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.

*[(7)]***(8)** Usual, customary, and reasonable fee allowed—non-network medical claims are allowed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(8)]***(9)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(9)]***(10)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(11) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (4), (6), and (7); adding new sections (5) and (10); and renumbering as needed.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding how the subscriber is determined when both spouses are state employees, the percentage of usual, customary, and reasonable fees allowed, and timeframe for filing claims.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri***

*and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars ($600); family each calendar year, one thousand two hundred dollars ($1,200). Non-network: per individual each calendar year, one thousand two hundred dollars ($1,200); family each calendar year, two thousand four hundred dollars ($2,400).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out-of-network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(4) Married, active employees who are MCHCP subscribers *[need to]* **and have enrolled children may** meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. *[Each subscriber will have access to all claim and payment information of the family unit.]* **In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber.** Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

*[(6)]***(7)** Usual, customary, and reasonable limit fee allowed—non-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(7)]***(8)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(8)]***(9)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(10) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), (6), (10), and (12); and adding new sections (5) and (9); and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, coinsurance, and out-of-pocket maximum amounts, the percentage of usual, customary, reasonable fees allowed, timeframes for filing claims, plan choices when a member becomes Medicare eligible, and the timing of health savings account (HSA) contributions.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits

and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Deductible amount—Network: per individual each calendar year, *[one thousand two hundred fifty dollars ($1,250)]* **one thousand six hundred fifty dollars ($1,650)**; family each calendar year, *[two thousand five hundred dollars ($2,500)]* **three thousand three hundred dollars ($3,300)**. Non-network: per individual each calendar year, *[two thousand five hundred dollars ($2,500)]* **four thousand dollars ($4,000)**; family each calendar year, *[five thousand dollars ($5,000)]* **eight thousand dollars ($8,000)**.

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Out-of-pocket maximum—*[t]***T**he maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(C) Network out-of-pocket maximum for individual—*[two thousand five hundred dollars ($2,500)]* **three thousand three hundred dollars ($3,300)**.

(D) Network out-of-pocket maximum for family—*[five thousand dollars ($5,000)]* **six thousand six hundred dollars ($6,600)**.

(4) Married, active employees who are MCHCP subscribers *[need to]* **and have enrolled children may** meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must **provide the other spouse's Social Security Number (SSN) and** report the other spouse as eligible for coverage when newly hired and during the open enrollment process. *[Each subscriber will have access to all claim and payment information of the family unit.]* **In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber.** Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred.]* **following the date of service.** The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(6)]***(7)** Usual, customary, and reasonable fee allowed—*[n]***N**on-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(7)]***(8)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(9) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*[(8)]***(10)** A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (11) of this *[regulation]* **rule**, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

*[(9)]***(11)** A retiree becoming eligible for Medicare in the upcoming plan year may not enroll in the HDHP during open enrollment.

*[(10)]***(12)** If a subscriber is enrolled in the HDHP and his/her status changes to Medicare primary during the plan year, the subscriber must *[choose another plan]* **enroll in the PPO 300 Plan or PPO 600 Plan** within thirty-one (31) days of notice from MCHCP or if no

plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan. A new plan deductible and out-of-pocket maximum will apply.

*[(11)]***(13)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;
(B) Accident insurance;
(C) Disability insurance;
(D) Dental insurance;
(E) Vision insurance; or
(F) Long-term care insurance.

*[(12)]***(14)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must **be an active employee and** open an HSA with the bank designated by MCHCP.

(B) The MCHCP contributions will be deposited into the subscriber's HSA bi-annually **on the Friday after the first Thursdays in January and July** as follows:

[Deposit]	Subscriber Only	All other coverage levels
[January 4, 2013]	$150.00	$300.00
[July 5, 2013]	$150.00	$300.00

(C) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP bi-annual contributions will receive a prorated bi-annual contribution. A subscriber will not be able to voluntarily change his/her plan selection after the bi-annual contribution has been deposited into the subscriber's HSA.

(D) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP bi-annual contribution will receive a prorated bi-annual contribution based on the increased level of coverage.

(E) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution for a future month(s), MCHCP will not request a re-payment of the contribution(s).

(F) If both a husband and wife are state employees covered by MCHCP and they both enroll in an HDHP with HSA, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a three hundred dollar ($300) contribution to each spouse to total six hundred dollars ($600).

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded as the Medicare Supplement Plan Benefit offered by Missouri Consolidated Health Care Plan (MCHCP) is no longer available.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

(1) Benefit Provisions Applicable to the PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension; or
7. Depression with one (1) other disease management condition.

(B) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension with one (1) other disease management condition; or
7. Depression with one (1) other disease management condition.

(C) A member identified as eligible for disease management through medical and prescription drug claims will receive an invitation to participate.

(4) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or
(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or
(II) Drugs when all of the following are met:
(a) History of allergy to a particular drug;
(b) There is no effective alternative drug; and
(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
(II) Food allergy;
(III) Hymenoptera venom allergy (stinging insects);
(IV) Inhalant allergy; or
(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;
(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
(III) Thymoma; and
(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;
(II) Dust mite atopic dermatitis;
(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
(IV) Mold-induced allergic rhinitis;
(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: The following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a

provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined

by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test sentences (HINT), and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multi-syllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

23. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status; and

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. The professional fee for automated lab work is not a covered service;

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care

that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborn will be subject to coinsurance and deductible if mother is not covered under the plan;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g. inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering the rest of the sections as subsections as necessary.

PURPOSE: This amendment revises language regarding acts of war, alternative therapies, and custodial or domiciliary care; and adds language regarding charges exceeding vendor contracted rates or benefit limits, cosmetic procedures, bundled devices or supplies, telehealth, and therapies.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency

amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein*[.]* **or in 22 CSR 10-2.055.**

*[(2)]***(A)** Abortion*[—other than situations where]* **unless** the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

*[(3)]***(B)** Acts of war **including**—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

*[(4)]***(C)** Alternative therapies—**that are outside conventional medicine** including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

*[(5)]***(D)** Assistive listening device.

*[(6)]***(E)** Assistant surgeon services—*[not covered]* unless determined to meet the clinical eligibility for coverage under the plan.

*[(7)]***(F)** Athletic *[trainer]* **training** services*[—services by a licensed athletic trainer not covered]*.

*[(8)]***(G)** Autopsy.

*[(9)]***(H)** Birthing center.

*[(10)]***(I)** Blood donor expenses*[—not covered]*.

*[(11)]***(J)** Blood pressure cuffs/monitors*[—not covered]*.

*[(12)]***(K)** Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

*[(13)]***(M)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(14)]***(N)** Childbirth classes.

*[(15)]***(O)** Comfort and convenience items.

(P) Cosmetic procedures.

*[(16)]***(Q)** Custodial or domiciliary care—*[includes]* **including** services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be *[provided]* **performed** by persons *[without the training of a health care provider]* **who are not providers**.

(R) Devices or supplies bundled as part of a service are not separately covered.

*[(17)]***(S)** Educational or psychological testing*[—not covered]* unless part of a treatment program for covered services.

*[(18)]***(T)** Examinations requested by a third party.

[(19) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.]

*[(20)]***(U)** Exercise equipment.

*[(21)]***(V)** Experimental *[services]* or investigational services*[—experimental or investigational services]*, procedures, supplies, or drugs as determined by the claims administrator *[are not covered]*.

*[(22)]***(W)** Eye services*[—health services]* and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(23)]***(X)** Services obtained at a government facility*[—not covered]* if care is provided without charge.

*[(24)]***(Y)** Gender reassignment*[—health]* services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

*[(25)]***(Z)** Health and athletic club membership—including costs of enrollment.

*[(26)]***(AA)** Home births.

*[(27)]***(BB)** Immunizations requested by third party *[or for travel]*.

*[(28)]***(CC)** Infertility treatment*[. Services are]* **beyond the** covered **services** to diagnose the condition.

*[(29)]***(DD)** Level of care, *[if]* greater than is needed for the treatment of the illness or injury.

*[(30)]***(EE)** Long-term care.

*[(31)]***(FF)** Maxillofacial surgery.

*[(32)]***(GG)** Medical care and supplies*[—not covered]* to the extent that they are payable under—

*[(A)]***1.** A plan or program operated by a national government or one (1) of its agencies; or

*[(B)]***2.** Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(33)]***(HH)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(34)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(35)]***(JJ)** Never events—*[twenty-eight (28)]* **never events are twenty-nine (29)** occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. *[They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.]*

*[(36)]***(KK)** Nocturnal enuresis alarm.

*[(37)]***(LL)** Not medically-necessary services.

*[(38)]***(MM)** Orthoptics.

*[(39)]***(NN)** Other charges **as follows:**

1. *[—no coverage for charges]* **Charges** that would not **otherwise** be incurred if the subscriber was not covered **by the plan***[.]***;**

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted*[.]***;**

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan*[.]***; and**

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

*[(40)]***(OO)** Over-the-counter medications with or without a prescription including but not limited to analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(41)]***(PP)** Physical fitness.

*[(42)]***(QQ)** Private-duty nursing.

*[(43)]***(RR)** Self-inflicted injuries—not covered unless related to a mental diagnosis.

*[(44)]***(SS)** Sex therapy.

*[(45)]***(TT)** Surrogacy—pregnancy coverage is limited to plan member.

(UU) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(VV) Therapy. Physical, occupation, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic performance or for recreation;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training;

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(46)]***(WW)** Travel expenses*[—not covered except for transplants in a transplant network facility:]*.

*[(47)]***(XX)** Workers' Compensation*[—charges for]* services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is deleting subsection (4)(B).

PURPOSE: This amendment removes language regarding the MCHCP Medicare Supplement Plan which is no longer available.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

[(B) In the event that MCHCP is a secondary plan as to one (1) or more plans, the benefits of MCHCP's Medicare Supplement Plan may be reduced so as not to exceed the amount due to the provider after the benefits of the other plan have been applied. MCHCP will compare what it would have paid in absence of this COB provision to the remainder due after the benefits of the other plan were applied and pay up to what it would have paid but not more than is due the provider.]

*AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (4), and (6), and adding a new section (7).

PURPOSE: This amendment revises the services applicable to this rule, the addresses and phone numbers to direct appeals, and the guidelines under which the Board of Trustees and/or staff may grant an appeal.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(2) Claims Submissions and Initial Benefit Determinations **for Medical and Non-Medicare Primary Pharmacy Services**.

(3) General Appeal Provisions **for Medical and Non-Medicare Primary Pharmacy Services**.

(4) Appeal Process for Medical and **Non-Medicare Primary** Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
[8320 Ward Parkway] **9401 Indian Creek Parkway, Suite 1300**
[Kansas City, MO 64114] **Overland Park, KS 66210**

(b) Expedited appeals must be communicated by calling *[(816) 221-8400]* **(913) 202-5000** or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route *[0390]* **BL0390**
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

[Office of Consumer Information and Oversight
Department of Health and Human Services
PO Box 791
Washington, DC 20044
or by fax to (202) 606-0036
or by email to disputedclaim@opm.gov]
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number *[(877) 549-8152]* **(888) 866-6205** with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines*[.]***:**

[(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's birth date.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage, except that no changes will be considered for High Deductible Health

Plan selections after the first MCHCP Health Savings Account contributions has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(I) Loss of coverage notice—MCHCP may approve a late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) Wellness participation—MCHCP may deny all appeals regarding continuation of participation in the Strive for Wellness Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.]

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the initial request is made in writing to the board of trustees within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal for the request to be considered;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected during the annual open enrollment period if the request is made within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. The subscriber must include payment in full for all past and current premiums due for reinstatement;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve an appeal to change a subscriber's medical plan coverage level prospectively, if the appeal is received within the first thirty (30) days of the start of coverage, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contributions has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(H) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is timely from date of late notice;

(I) MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period;

(J) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline;

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; and

(M) MCHCP may approve appeals of a late submission of a Preventive Lab form if the subscriber can provide substantiating evidence that the preventive lab screening was received timely, that the subscriber reasonably relied on the health care provider to submit the Preventive Lab form to the wellness vendor, and the health care provider failed to submit the Preventive Lab form to the wellness vendor prior to the May 31 due date.

(7) Medicare Primary Pharmacy Appeals.

(A) Appeals rights and procedures for Medicare primary pharmacy services are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Pharmacy Employer Group Waiver Plan vendor, Express Scripts, for additional information on appeal rights and procedures.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for Medicare-primary members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) The following Medicare primary members enrolled in the PPO 300, PPO 600, or the Medicare Prescription Drug Only Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan:

1. Active employee members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage.

(B) The non-Medicare primary dependents of Medicare primary members will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(C) Foster parent members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(D) A retiree Medicare primary member who chooses not to be in the Medicare Prescription Drug Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical or Medicare Prescription Drug Plan at a later date.

(E) MCHCP will pay the Medicare financial penalty incurred by a Medicare primary member who has had a continuous gap in prescription drug coverage of sixty-three (63) days or more after the Medicare Initial Election Period (IEP) and was not covered by any creditable prescription drug coverage and failed to enroll into Part D.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicare Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach two thousand eight hundred fifty dollars ($2,850), the member will pay the following copayments:

A. Generic Formulary Drugs: thirty-one- (31-) day supply has an eight dollar ($8) copayment; sixty- (60-) day supply has a sixteen dollar ($16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar ($24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar ($20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar ($35) copayment; sixty- (60-) day supply has a seventy dollar ($70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar ($105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent ($87.50) copayment; and

C. Non-preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment.

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed two thousand eight hundred fifty dollars ($2,850) and remain below four thousand five hundred fifty dollars ($4,550), the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach four thousand five hundred fifty dollars ($4,550);

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach four thousand five hundred fifty dollars ($4,550), the member will pay the greater of—

A. Five percent (5%) coinsurance or a two dollar fifty-five cent ($2.55) copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or a six dollar thirty-five cent ($6.35) copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

(G) Medications covered under 22 CSR 10-2.090 will be covered under the Medicare Prescription Drug Plan as Non-Part D medications when they are not a Part D covered drug.

(H) Medicare Part B Prescription Drugs. For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:

1. Diabetes testing and maintenance supplies;
2. Respiratory agents;
3. Immunosuppressants; and
4. Oral anti-cancer medications.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (8), deleting section (7), adding a new section (9), and renumbering as necessary.

PURPOSE: This amendment revises language regarding coverage for prescription drugs for non-Medicare primary members; PPO 300 and PPO 600 plan member copayments, home delivery days supply, and maintenance prescription fill selection; prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine and contraception covered at one hundred percent (100%); HDHP with HSA plan coinsurance, home delivery days supply, maintenance prescription fill selection, prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine and contraception covered at one hundred percent (100%); and formulary updates and quantity level limits. This amendment adds language regarding compound drug copayments and out-of-pocket maximum amounts for members enrolled in the PPO 300 and PPO 600 plans; and removes language regarding Medicare Part B prescriptions coordination of coverage.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) The pharmacy benefit provides coverage for prescription drugs*[. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician]* **to non-Medicare primary members**.

(A) PPO 300*[,]* **and** PPO 600*[, and Medicare Supplement Plan Prescription Drug Coverage]*.

1. Network:

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply** for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply** for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply** for a drug not on the formulary;

D. Home delivery program*[—]***.**

(I) Maintenance prescriptions may be filled through the home delivery program *[or through a retail pharmacy that has agreed to fill maintenance prescriptions at a comparable price to the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits]*.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

[(II) Select home delivery—]

*[(a)]***(d)** A member must choose how *[s/he will fill his/her]* maintenance prescription*[(]s[). A member must]* **will be filled by** notif*[y]***ing** the pharmacy benefit manager **(PBM)** of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

*[(b)]***I.** If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the *[pharmacy benefit manager]* **PBM** of his/her decision, the first two (2) maintenance prescription orders *[can]* **may** be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the *[pharmacy benefit manager]* **PBM** of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. *[Once the pharmacy benefit manager has been notified of the member's decision to purchase his/her maintenance prescription(s) through a retail pharmacy, the retail election remains in place for one (1) year. After one (1) year, the member will be required to make a choice between home delivery and retail pharmacy for maintenance prescriptions]* **If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will**

be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

*[(c)]***II.** Once a member makes his/her delivery *[election]* **decision**, the member can modify *[his/her election]* **the decision** by contacting the *[pharmacy benefit manager]* **PBM**; and

*[(III)]***(II)** Specialty drugs **are** covered only through *[network]* **the specialty** home delivery **network** for up to thirty-**one-** *[(30-)]* **(31-)** day*[s]* **supply**. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayment: Eight dollars ($8) for a generic drug on the formulary list.

(b) Brand copayment: Thirty-five dollars ($35) for a brand drug on the formulary.

(c) Non-formulary copayment: One hundred dollars ($100) for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix;

*[F.]***G.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[G.]***H.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug; and

*[H.]***I.** *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%), as prescribed by a physician and included on the formulary through the pharmacy benefit manager.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less the applicable copayment.

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

3. Out-of-pocket maximum. The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

A. Network and non-network out-of-pocket maximums are not separate;

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount;

C. Individual—six thousand two hundred fifty dollars ($6,250);

D. Family—twelve thousand dollars ($12,000).

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network:

A. Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

B. Brand: Twenty percent (20%) coinsurance after deductible **has been met** for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

C. Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. *[Some medications may not qualify for the program because they require prior authorization or quantity level limits.]*

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(b) Brand: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs covered only through network home delivery for up to thirty-**one-** *[(30-)]* **(31-)** days.

(a) Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a generic drug on the formulary*[.]***;**

(b) Brand: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a brand drug on the formulary*[.]***;**

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary; *[and]*

E. *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other, more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first-step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the physician may request a prior authorization from the *[pharmacy benefit manager]* **PBM**. If the prior authorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(3) Disease Management **(DM)** Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the *[Disease Management]* **DM** Program and enrolled in the PPO 300 Plan or PPO 600 Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the *[Disease Management]* **DM** Program when s/he is enrolled in a *[Disease Management]* **DM** Program through the medical plan vendor and one (1) of the following:

1. Is working one-on-one with a **DM** nurse; *[or]*

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a **DM** nurse until **the medical plan vendor determines** the condition *[is]* **can be** managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a **DM** nurse.

(4) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. *[Members]* **A member** may request **a** claim form*[s]* from the plan or the *[pharmacy benefit manager]* **PBM**. In order to file a claim, **the** member*[s]* must—

(C) *[Members]* **A member** must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less any applicable copayment, deductible, or coinsurance. *[Members are]* **A member is** responsible for any charge over the network discounted price and the applicable copayment.

(5) Formulary*[—]***.** The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; *[or]*

(C) A drug is determined to have a safety issue **by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer under the pharmacy benefit**.

[(7) Medicare Part B Prescription Drugs—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

(A) Diabetes testing and maintenance supplies;

(B) Respiratory agents;

(C) Immunosuppressants; and

(D) Oral anti-cancer medications.]

*[(8)]***(7)** Quantity Level Limits*[—]***.** Quantities of some medications may be limited based on recommendations by the *[Food and Drug Administration and]* **FDA or credible scientific evidence published in peer-reviewed** medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

*[(9)]***(8)** Guidelines for Drug Use*[—]***.** If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those

medications prescribed by an assigned physician approved by MCHCP.

(9) Affordable Care Act (ACA) required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.140 Wellness Center Provisions, Charges, and Services

PURPOSE: This rule establishes the policy of the board of trustees in regard to provisions, charges, and services available to members of the Missouri Consolidated Health Care Plan (MCHCP) through the MCHCP Wellness Center.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting employee members enrolled in the Missouri Consolidated Health Care Plan (MCHCP) by allowing such members to take advantage of opportunities for more affordable health care options without which they may forgo accessing needed medical care. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the health care plan by providing wellness center services at a lesser cost to help stabilize premiums and plan expenditures. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Eligibility. Active employees enrolled in an MCHCP medical plan shall be eligible for and able to access the services available at the wellness center as described in this rule.

(2) Available Services. The wellness center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(A) Sore throats/ears/headache;
(B) Strains/sprains/musculoskeletal problems;
(C) Non-specific abdominal pain;
(D) Non-specific chest pain;
(E) Cough;
(F) Sinus conditions;
(G) Allergy injections;
(H) Hormone injections;
(I) Immunizations including immunization for influenza;
(J) Biometric screenings;
(K) Rashes;
(L) Acute urinary complaints;
(M) Personal hygiene related problems;
(N) Acute injuries/acute routine office procedures;
(O) Emergency First-Response for worksite injuries;
(P) Minor surgical procedures, such as sutures for laceration treatment;
(Q) Ordinary and routine care of the nature of a visit to the doctor's office;
(R) Treatment and monitoring of diabetes and hypertension; and
(S) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.

(3) Limitations and Exclusions.

(A) The following employees are not eligible for the wellness center:

1. Active employees who are not enrolled in an MCHCP medical plan;
2. Dependents of active employees; and
3. Retirees and their dependents.

(B) Services that are beyond the scope of practice of the wellness center including, but not limited to, the following:

1. Emergency services;
2. Urgent care services;
3. Radiology services;
4. Specialist services;
5. Pharmacy services;
6. Occupational, speech, and physical therapy services; and
7. Chiropractic services.

(4) Charges for the following services apply:

(A) Office visit—

1. For active employees enrolled in the MCHCP PPO 300 or PPO 600 Plan, fifteen dollars ($15) payable at the time of service;
2. For active employees enrolled in the High Deductible Health Plan, forty-five dollars ($45) payable at the time of service; and
3. The office visit includes the evaluation and management of the patient and any associated laboratory services.

(B) Preventive care—

1. For active employees enrolled in the MCHCP PPO 300 Plan, PPO 600 Plan, or High Deductible Health Plan, preventive care is covered at one hundred percent (100%); and
2. Preventive care shall have the same meaning as in 22 CSR 10-2.055.

(C) Wellness center services are outside the MCHCP PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan benefits and payments for center services do not apply toward any associated deductible or out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending section (41).

PURPOSE: This amendment revises the term chemical dependency to substance use disorder and revises the definition of medically necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(27) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/*[chemical dependency]* **substance abuse disorder** office visits;

(41) Medically necessary. **The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary** *[T]***t**reatments, procedures, services, or supplies that the plan administrator **or its designee** determines, in the exercise of its discretion **are**—

(A) *[Are e]***E**xpected to be of clear clinical benefit to the *[patient]* **member**; *[and]*

(B) *[Are appropriate for the care and treatment of the injury or illness in question; and]* **Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;**

(C) *[Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.]* **In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;**

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (5), (8), (9), and (10); and renumbering as necessary.

PURPOSE: This amendment revises language regarding eligibility for new enrollments of disabled children over the age of twenty-six (26) years and the time period COBRA disabled members may continue coverage; and adds the timeframe for reinstating medical coverage after a voluntary cancelation.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency*

*amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is fully vested in the retirement plan upon termination and the public entity remains with MCHCP. The public entity must make the benefits available to all retirees, past and future, who meet the vesting requirements. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If the retiree's spouse is an active public entity employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

3. A retiree who returns to employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

4. *[If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.]* **An employee who is eligible to continue coverage as a retiree must submit the Retiree Enrollment form at least thirty (30) days prior to the effective date of retirement.**

A. If the Retiree Enrollment form is not submitted thirty (30) days prior to the effective date of retirement the employee shall not thereafter be eligible for coverage.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled dependent or a currently enrolled permanently disabled dependent turning age twenty-six (26) **years and** may continue coverage beyond age twenty-six (26) **years**, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the currently enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled dependent:

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26) **years**. Evidence could be from the Social Security Administration, representation from the dependent's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the Social Security Administration (SSA) confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) **years** is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends **or never take effect for new enrollment requests**.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP to cancel coverage.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the cafeteria plan.

2. A subscriber may reinstate medical coverage after a voluntary cancelation by submitting an Enroll/Change/Cancel/Waive form prior to the end of current coverage.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing public entity must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is terminated effective the last day of the month in which the employee is employed.

[3. If the employee fails to pay the premium due to the public entity, coverage on the employee and his/her dependents terminates.]

*[4.]***3.** If the employee's spouse is an active employee or retiree, the employee may transfer coverage under the plan in which the spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

*[5.]***4.** Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed **Enroll/Change/Cancel/Waive** form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

*[6.]***5.** If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible

for Medicare.

4. A surviving spouse and dependents who have coverage due to the death of a non-vested employee may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) own expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage **and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage**, the member may continue coverage for up to *[twenty-nine (29)]* **an additional eleven (11)** months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises language regarding the amount of time the member is given to submit additional documentation for prior authorizations and removes language regarding the shingles vaccine.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) **years**, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service*[. Annual dollar limit may be exceeded with prior authorization]*;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care;

N. Hospice care and palliative services;

O. Hospital inpatient services except for observation stays;

P. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

Q. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

R. Nutritional counseling after three (3) sessions annually;

S. Orthognathic surgery;

T. Orthotics over one thousand dollars ($1,000);

U. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

V. Procedures with codes ending in "T";

W. Prostheses over one thousand dollars ($1,000);

X. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Y. Skilled nursing facility;

Z. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery

(excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

AA. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; **and**

F. Medication with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications*[; and]***.**

[G. Shingles vaccines prescribed by a physician.]

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least *[forty-five (45)]* **ninety (90)** calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (6); adding new sections (5) and (9), and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, who will have access to claim and payment information and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, copayment, and out-of-pocket maximum amounts, the percentage of usual, customary, and reasonable fees allowed, and timely filing of claims.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family each calendar year, six thousand dollars ($6,000).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Copayments—set charges for the following services apply as long as network providers are utilized unless otherwise specified. Copayments do not apply to the deductible *[or out-of-pocket maximum]*.

(A) Office visit—*[Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.]* **Office visit—primary care: twenty-five dollars ($25); specialist: forty dollars ($40); chiropractor office visit and/or manipulation: twenty dollars ($20); urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance**.

1. Vision office visit or refraction—*[thirty dollars ($30)]* **forty dollars ($40)**.

2. Hearing test—performed by a primary care physician: *[twenty dollars ($20)]* **twenty-five dollars ($25)**; performed by a specialist: *[thirty dollars ($30)]* **forty dollars ($40)**.

[(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; one hundred percent (100%) coverage for routine prenatal office visits and recommended screenings; lab—covered at one hundred percent (100%); other services and diagnostic tests—ninety percent (90%) coinsurance after deductible; Non-network: all services paid at seventy percent (70%) coinsurance after deductible.]

*[(C)]***(B)** Emergency room—*[Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).]* **two hundred dollars ($200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.**

[(D) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(E) Bariatric surgery—five hundred dollar ($500) copayment and ten percent (10%) coinsurance after deductible is met.]

(4) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(D) Network out-of-pocket maximum for family—*[thirteen thousand five hundred dollars ($13,500)]* **twelve thousand five hundred dollars ($12,500)**.

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: *[copayments;]* charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed amount for transplants performed by a non-network provider.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(6)]***(7)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(7)]***(8)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(9) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RESCISSION

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded as the PPO Plan Benefit offered by Missouri Consolidated (MCHCP) is no longer available.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan

is amending sections (1), (2), (3), (4), and (5); adding new sections (4) and (10); and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, coinsurance, and out-of-pocket maximum amounts, the percentage of usual, customary, and reasonable fees allowed, and timeframes for filing claims.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Deductible amount—*[n]***N**etwork: per individual each calendar year, *[one thousand two hundred fifty dollars ($1,250)]* **one thousand six hundred fifty dollars ($1,650)**; family each calendar year, *[two thousand five hundred dollars ($2,500)]* **three thousand three hundred dollars ($3,300)**. Non-network: per individual each calendar year, *[two thousand five hundred dollars ($2,500)]* **four thousand dollars ($4,000)**; family each calendar year, *[five thousand dollars ($5,000)]* **eight thousand dollars ($8,000)**.

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Out-of-pocket maximum—*[t]***T**he maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(C) Network out-of-pocket maximum for individual—*[two thousand five hundred dollars ($2,500)]* **Three thousand three hundred dollars ($3,300).**

(D) Network out-of-pocket maximum for family—*[five thousand dollars ($5,000)]* **Six thousand six hundred dollars ($6,600)**.

(4) Each subscriber will have access to all claim and payment information of the family unit.

*[(4)]***(5)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred.]* **following the date of service.** The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(5)]***(6)** Usual, customary, and reasonable fee allowed—*[n]***N**on-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(6)]***(7)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(7)]***(8)** A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (8) of this *[regulation]* **rule**, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

*[(8)]***(9)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(10) Services received while out of the country may be covered if the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4), adding new sections (5) and (8), and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding the percentage of usual, customary, and reasonable fees allowed, and timeframe for filing claims.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) Deductible amount—*[n]*Network: per individual each calendar year, six hundred dollars ($600); family each calendar year, one thousand two hundred dollars ($1,200). Non-network: per individual each calendar year, one thousand two hundred dollars ($1,200); family each calendar year, two thousand four hundred dollars ($2,400).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—*[c]*Coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]*Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(4) Usual, customary, and reasonable fee allowed—Non-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Any claim must be submitted **initially** within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(6)]***(7)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(8) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RESCISSION

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. This rule established the policy of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees,

*officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2013, becomes effective Jan. 1, 2014, and expires June 29, 2014.*

(1) Benefit Provisions Applicable to the PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension; or

7. Depression with one (1) other disease management condition.

(B) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension with one (1) other disease management condition; or
7. Depression with one (1) other disease management condition.

(C) A member identified as eligible for disease management through medical and prescription drug claims will receive an invitation to participate.

(4) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents).

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents).

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or
(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
(II) Skin testing is unreliable.

H. Exercise Challenge Testing for exercise-induced bronchospasm

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or
(II) Drugs when all of the following are met:
(a) History of allergy to a particular drug;
(b) There is no effective alternative drug; and
(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
(II) Food allergy;
(III) Hymenoptera venom allergy (stinging insects);
(IV) Inhalant allergy; or
(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;
(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
(III) Thymoma; and
(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;
(II) Dust mite atopic dermatitis;
(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
(IV) Mold-induced allergic rhinitis;
(V) Perennial rhinitis;
(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:
(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
(b) Member has a life-threatening allergy to insect stings; or
(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: The following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy; and

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy.

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type two II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only:

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g.,Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when:

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz: and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test sentences (HINT), and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multi-syllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500).

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

23. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status;

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. The professional fee for automated lab work is not a covered service;

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborn will be subject to coinsurance and deductible if mother is not covered under the plan;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions;

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom.

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis; and

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person.

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, *[PPO 2000 Plan,]* **and HDHP Limitations**. The Missouri Consolidated Health Care Plan is amending the title of the rule, section (1), and renumbering the rest of the sections and subsections as necessary.

PURPOSE: This amendment revises language regarding acts of war, alternative therapies, and custodial or domiciliary care; and adds language regarding charges exceeding vendor contracted rates or benefit limits, cosmetic procedures, bundled devices or supplies, telehealth, and therapies.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures*

best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein **or in 22 CSR 10-3.057.**

*[(2)]***(A)** Abortion*[—other than situations where]* **unless** the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

*[(3)]***(B)** Acts of war **including**—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

*[(4)]***(C)** Alternative therapies—**that are outside conventional medicine** including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

*[(5)]***(D)** Assistive listening device.

*[(6)]***(E)** Assistant surgeon services—*[not covered]* unless determined to meet the clinical eligibility for coverage under the plan.

*[(7)]***(F)** Athletic *[trainer]* **training** services*[—services by a licensed athletic trainer not covered]*.

*[(8)]***(G)** Autopsy.

*[(9)]***(H)** Birthing center.

*[(10)]***(I)** Blood donor expenses*[—not covered]*.

*[(11)]***(J)** Blood pressure cuffs/monitors*[—not covered]*.

*[(12)]***(K)** Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

*[(13)]***(M)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(14)]***(N)** Childbirth classes.

*[(15)]***(O)** Comfort and convenience items.

(P) Cosmetic procedures.

*[(16)]***(Q)** Custodial or domiciliary care—*[includes]* **including** services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be *[provided]* **performed** by persons *[without the training of a health care provider]* **who are not providers**.

(R) Devices or supplies bundled as part of a service are not separately covered.

*[(17)]***(S)** Educational or psychological testing*[—not covered]* unless part of a treatment program for covered services.

*[(18)]***(T)** Examinations requested by a third party.

[(19)] Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.]

*[(20)]***(U)** Exercise equipment.

*[(21)]***(V)** Experimental *[services]* or investigational services*[—experimental or investigational services,]* procedures, supplies, or drugs as determined by the claims administrator *[are not covered]*.

*[(22)]***(W)** Eye services*[—health services]* and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(23)]***(X)** Services obtained at a government facility*[—not covered]* if care is provided without charge.

*[(24)]***(Y)** Gender reassignment*[—health]* services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

*[(25)]***(Z)** Health and athletic club membership—including costs of enrollment.

*[(26)]***(AA)** Home births.

*[(27)]***(BB)** Immunizations requested by third party *[or for travel]*.

*[(28)]***(CC)** Infertility treatment*[.]* **beyond the** *[Services are]* covered **services** to diagnose the condition.

*[(29)]***(DD)** Level of care, *[if]* greater than is needed for the treatment of the illness or injury.

*[(30)]***(EE)** Long-term care.

*[(31)]***(FF)** Maxillofacial surgery.

*[(32)]***(GG)** Medical care and supplies*[—not covered]* to the extent that they are payable under—

*[(A)]***1.** A plan or program operated by a national government or one (1) of its agencies; or

*[(B)]***2.** Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(33)]***(HH)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(34)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(35)]***(JJ)** Never events—*[twenty-eight (28)]* **never events are twenty-nine (29)** occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting*[. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability]*.

*[(36)]***(KK)** Nocturnal enuresis alarm.

*[(37)]***(LL)** Not medically-necessary services.

*[(38)]***(MM)** Orthoptics.

*[(39)]***(NN)** Other charges **as follows:**

1. *[—no coverage for charges]* **Charges** that would not **otherwise** be incurred if the subscriber was not covered **by the plan***[.]***;**

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted*[.]***;**

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan*[.]***; and**

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

*[(40)]***(OO)** Over-the-counter medications with or without a prescription including but not limited to analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(41)]***(PP)** Physical fitness.

*[(42)]***(QQ)** Private-duty nursing.

*[(43)]***(RR)** Self-inflicted injuries—not covered unless related to a mental diagnosis.

*[(44)]***(SS)** Sex therapy.

*[(45)]***(TT)** Surrogacy—pregnancy coverage is limited to plan member.

(UU) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(VV) Therapy. Physical, occupation, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic performance or for recreation;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs);

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance;

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(46)]***(WW)** Travel expenses*[—not covered except for transplants in a transplant network facility]*.

*[(47)]***(XX)** Workers' Compensation*[—charges for]* services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (4) and (6).

PURPOSE: This amendment revises the addresses and phone numbers to direct appeals and the guidelines under which the Board of Trustees and/or staff may grant an appeal.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(4) Appeal Process for Medical and Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-32.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination

giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
[8320 Ward Parkway] **9401 Indian Creek Parkway, Suite 1300**
[Kansas City, MO 64114] **Overland Park, KS 66210**

(b) Expedited appeals must be communicated by calling *[(816) 221-8400]* **(913) 202-5000** or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route *[0390]* **BL0390**
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

[Office of Consumer Information and
Oversight
Department of Health and Human Services
PO Box 791
Washington, DC 20044
or by fax to (202) 606-0036
or by email to disputedclaim@opm.gov]
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number *[(877) 549-8152]* **(888) 866-6205** with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability

of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines*[.]*:

[(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's birth date.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan.

(I) Loss of coverage notice—MCHCP may approve a late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(K) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(L) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan.]

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn retroactively to the date of birth if the initial request is made in writing to the board of trustees within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal for the request to be considered;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected during the annual open enrollment period if the request is made within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. The subscriber must include payment in full for all past and current premiums due for reinstatement;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by a cafeteria plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is timely from date of late notice;

(H) MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period;

(I) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan;

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline; and

(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (8), adding a new section (9), and renumbering as necessary.

PURPOSE: This amendment revises language regarding PPO 600 and PPO 1000 plan member copayments, home delivery days supply, maintenance prescription fill selection, prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine, and contraception covered at one hundred percent (100%); HDHP with HSA plan coinsurance, home delivery days supply, and maintenance prescription fill selection, prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine, and contraception covered at one hundred percent (100%); and formulary updates, Disease Management eligibility for reduced copayments and quantity level limits. This amendment adds language regarding compound drug copayments and out-of-pocket maximum amounts for members enrolled in the PPO 600 and PPO 1000 plans.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2014, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to employee members as one method of protecting the MCHCP trust fund from more costly expenses. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment was filed October 30, 2013, becomes effective January 1, 2014, and expires June 29, 2014.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) *[PPO 600, PPO 1000, and PPO 2000]* **PPO 600 and PPO 1000** Prescription Drug Coverage.

1. Network:

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply** for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply** for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply** for a drug not on the formulary;

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program *[or through a retail pharmacy that has agreed to fill maintenance prescriptions at a comparable price to the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits]*.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply, and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

[(II) Select home delivery—]

*[(a)]***(d)** A member must choose how *[s/he will fill his/her]* maintenance prescription(s)*[. A member must notify]* **will be filled by notifying** the pharmacy benefit manager **(PBM)** of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

*[(b)]***(e)** If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the *[pharmacy benefit manager]* **PBM** of his/her decision, the first two (2) maintenance prescription orders *[can]* **may** be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the *[pharmacy benefit manager]* **PBM** of his/her decision to continue to fill the maintenance prescription at the

retail pharmacy. *[Once the pharmacy benefit manager has been notified of the member's decision to purchase his/her maintenance prescription(s) through a retail pharmacy, the retail election remains in place for one (1) year. After one (1) year, the member will be required to make a choice between home delivery and retail pharmacy for maintenance prescriptions]* **If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision**; and

*[(c)]***(f)** Once a member makes his/her delivery *[election]* **decision**, the member can modify *[his/her election]* **the decision** by contacting the *[pharmacy benefit manager]* **PBM**; and

*[(III)]***(II)** Specialty drugs **are** covered only through *[network]* **the specialty** home delivery **network** for up to **a** *[thirty (30) days]* **thirty-one- (31-) day supply**. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayments: Eight dollars ($8) for a generic drug on the formulary list.

(b) Brand copayments: Thirty-five dollars ($35) for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred*[-]*dollars ($100) for a drug not on the formulary; and

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount**;**

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix;

*[F.]***G.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[G.]***H.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

*[H.]***I.** *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%), as prescribed by a physician and included on the formulary through the pharmacy benefit manager.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less the applicable copayment.

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

3. Out-of-pocket maximum. The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

A. Network and non-network out-of-pocket maximums are not separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—six thousand two hundred fifty dollars ($6,250).

D. Family—twelve thousand dollars ($12,000)

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network:

A. Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

C. Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. *[Some medications may not apply for the program because they require prior authorization or quantity level limits.]*

(a) Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible for a generic drug on the formulary*[; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)]*.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary*[; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)]*.

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs covered only through network home delivery for up to thirty-**one-** *[(30)]* **(31-)** days.

(a) Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible **has been met** for a brand drug on the formulary.

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary; and

E. *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first-step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the physician may request a prior authorization from the *[pharmacy benefit manager]* **PBM**. If the prior authorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(3) Disease Management **(DM)** Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the *[Disease Management]* **DM** Program and enrolled in the PPO 600 Plan*[,]* **or** PPO 1000 Plan*[, or PPO 2000 Plan]* are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the *[Disease Management]* **DM** Program when s/he is enrolled in a *[Disease Management]* **DM** Program through the medical plan vendor and one (1) of the following*[—]***:**

1. Is working one-on-one with a nurse; or

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a nurse until **the medical plan vendor determines** the condition *[is]* **can be** managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a **DM** nurse.

(C) A member is no longer eligible for reduced non-formulary prescription copayment when the medical plan vendor determines s/he is no longer actively participating in the DM program.

(4) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. *[Members]* **A member** may request **a** claim form*[s]* from the plan or the *[pharmacy benefit manager]* **PBM**. In order to file a claim, **the** member*[s]* must—

(C) *[Members]* **A member** must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less any applicable copayment, deductible, or coinsurance. *[Members are]* **A member is** responsible for any charge over the network discounted price and the applicable copayment.

(5) Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; *[or]*

(C) A drug is determined to have a safety issue **by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer covered under the pharmacy benefit**.

(8) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the *[Food and Drug Administration and]* **FDA or credible scientific evidence published in peer-reviewed** medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

(10) Affordable Care Act (ACA) required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 10—Food Safety and Meat Inspection

PROPOSED AMENDMENT

2 CSR 30-10.010 Inspection of Meat and Poultry. The acting director is amending section (2).

*PURPOSE: This amendment ensures that the current rule language clearly includes the most recent publication date of Title 9, the **Code of Federal Regulations** published January 1 of each calendar year for the Missouri Meat and Poultry Inspection Program to be in compliance with federal regulations and maintain "equal to" status as determined by the United States Department of Agriculture/Food Safety and Inspection Service.*

(2) The standards used to inspect Missouri meat and poultry slaughter and processing shall be those shown in Part 300 to end of Title 9, the *Code of Federal Regulations* (January *[2013]* **2014**), herein incorporated by reference and made a part of this rule as published by the United States Superintendent of Documents, 732 N Capitol Street NW, Washington, DC 20402-0001, phone: toll-free (866) 512-1800, DC area (202) 512-1800, website: http://bookstore.gpo.gov. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: section 265.020, RSMo 2000. Original rule filed Sept. 14, 2000, effective March 30, 2001. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 21, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Linda Hickam, State Veterinarian, PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 8—Cosmetology Instructors and Instructor Trainees

PROPOSED AMENDMENT

20 CSR 2085-8.070 Instructor Renewal and Inactive License Requirements. The board is proposing to amend subsections (2)(A), (2)(C), and section (4), and add new subsections (4)(C), (D), and (E).

PURPOSE: This amendment decreases the continuing education requirements and provides another source of continuing education for cosmetology instructors.

(2) Renewals. Every two (2) years (biennially) the renewal application for active licensees must be completed, signed, accompanied by the appropriate renewal fee, and returned to the board office prior to the expiration date of the license. The biennial instructor renewal fee shall be submitted in addition to the regular operator renewal fee.

(A) Renewal is contingent upon attending a board-approved seminar and submitting to the board proof of *[twelve (12)]* **eight (8)** hours of attendance issued by seminar sponsors, showing the date and place of the seminar. Each licensed instructor shall be required to attend a board-approved seminar within the two (2) years immediately preceding the renewal date and shall submit evidence of attendance with the renewal application.

(C) Instructors holding a Missouri license, but not teaching or residing in Missouri, may attend an approved seminar of the state in which they reside for license renewal providing the program is sponsored by a university or bona fide cosmetology association and is at least *[twelve (12)]* **eight (8)** hours. All seminar certifications shall

contain a sworn statement from that state board that the program was approved for instructor license renewal. Should the state not have continuing education requirements for instructor license renewal, then the instructor license renewal would be contingent upon attending a seminar approved by the board.

(4) Approval of Instructor Seminar Training.

[(A) All seminar programs must be submitted by the sponsoring university or association to the board for approval prior to the first day of the calendar year in which the seminar is scheduled to be held and no later than sixty (60) days prior to the scheduled date of the seminar. Seminar programs submitted for approval must include the following information:

1. A copy of the proposed program schedule;

2. An outline of the subject matter;

3. The identity and qualifications of the speakers or instructors; and

4. The number of hours of the presentation (minimum of twelve (12) hours required).]

(A) A continuing education program for cosmetology instructors shall have prior approval of the Missouri Board of Cosmetology and Barber Examiners to fulfill the requirements of continuing education for renewal in Missouri. All cosmetology instructor continuing education approved by the board shall be accepted for continuing education credit for renewal of the cosmetology instructor license.

1. Continuing education includes, but is not limited to: institutes, seminars, lectures, conferences, workshops, extension study, correspondence courses, teaching, professional meetings, self-study courses, and any other methods approved by the board.

2. Continuing education shall be related to teaching methodology in the professions of cosmetology or barbering.

3. Continuing education shall provide for evaluation methods or examinations to ensure satisfactory completion by participants.

4. The person(s) instructing or otherwise delivering the content of the program shall be qualified in the subject matter by education or experience.

(B) *[Seminar sponsors shall be responsible for accurate attendance records and shall provide the board with an alphabetical listing of names, addresses and license numbers of those granted certificates of attendance and shall furnish evidence of attendance to the instructors showing the date and place of the seminar, signed by the sponsor secretary or chairman and shall indicate state board approved.]* **Submissions for approval of continuing education for cosmetology instructors' applications shall be submitted on forms provided by the board.**

(C) Submissions for approval of continuing education for cosmetology instructors shall be submitted by the sponsoring university, Missouri vocational association, or state cosmetology association to the board for approval no later than sixty (60) days prior to the scheduled date of the seminar. Seminar programs submitted for approval must include the following information:

1. A copy of the proposed schedule;

2. An outline of the subject matter;

3. The identity and qualifications of the speakers or instructors;

4. The number of hours of the presentation; and

5. The name, address, and telephone number of the entity offering the program or a representative of the program making the submission for approval.

(D) Submissions for approval of continuing education for cosmetology instructors that are returned due to errors in the submission or for purposes of requesting additional information required pursuant to subsection (4)(C) of this rule shall not be considered complete until the requested corrections are made or the board receives the additional information. The board shall notify the entity seeking approval or its representative in writing following the board's decision.

(E) The entity offering the program shall be responsible for accurate attendance records and shall provide the board with an alphabetical listing of names, addresses, and license numbers of those granted certificates of attendance. The entity offering the program shall furnish evidence of attendance to the instructors showing the date and place of the seminar, signed by the representative of the entity offering the program, and shall indicate that the program was approved by the board with the date of such approval.

*AUTHORITY: sections [620.150, RSMo 2000 and] 329.025.1 and 329.085, RSMo Supp. [2007] **2013**. Original rule filed Aug. 1, 2007, effective Feb. 29, 2008. Amended: Filed Nov. 26, 2013.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions between one thousand six hundred eighty-seven dollars and ninety-two cents ($1,687.92) and one thousand seven hundred eighty dollars and ninety-five cents ($1,780.95) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities approximately seventy-three thousand two hundred thirty-six dollars to ninety-nine thousand eighty-four dollars ($73,236–$99,084) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Cosmetology and Barber Examiners, Emily Carroll, Executive Director, PO Box 1062, Jefferson City, MO 65102, by facsimile at (573) 751-8167, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2085 - Cosmetology and Barber Examiners
Chapter 8 - Cosmetology Instructors and Instructor Trainees
Proposed Amendment - 20 CSR 2085-8.070 - Instructor Renewal and Inactive Licensee Requirements
Prepared April 5, 2013 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost	
Board of Cosmetology and Barber Examiners		$1,687.92 to $1,780.95
	Total Annual Costs of Compliance for the Life of the Rule	$1,687.92 to $1,780.95

III. WORKSHEET

The Processing Technician II prepares all continuing education review packets sent to board member(s), assists with the data entry of seminar information in an automated tracking system, and mails approval letters to continuing education providers. The Administrative Coordinator reviews applications to verify a correct fee is included and that the courses and instructors are identified and that their resumes are included. The Administrative Coordinator then coordinates the results with a board member and drafts applicable correspondence.

Personal Service Dollars

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Administrative Coordinator	$36,672 to $38,724	$55,525.08 to $58,632.01	$26.69 to $28.19	$0.44 to $0.47	60 minutes	$26.69 to $28.19	$1,601.68 to $1,691.31
Processing Technician II	$25,068 to $26,316	$37,955.46 to $39,845.06	$18.25 to $19.16	$0.30 to $0.32	15 minutes	$4.56 to $4.79	$68.43 to $71.84
			Total Estimated Annual Personnel Service Cost for the Life of the Rule				$1,670.11 to $1,763.14

Expense and Equipment Dollars

Item	Cost	Quantity	Total Cost Per Item
Correspondence Mailing	$0.65	13	$8.45
License Printing and Postage	$0.72	13	$9.36
	Total Estimated Annual Expense for the Life of the Rule		$17.81

IV. ASSUMPTION

1. Employees' salaries were calculated using the annual salary multiplied by 51.41% for fringe benefits and then divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute.
2. The number of entities listed in the table reflect an average of the estimated number of submissions for approval to provide instructor education. The board estimates there willl be 10 to 15 submissions yearly.
3. It is anticipated that the total costs will recur annually for the life of the rule, may vary with inflation, and is expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2085 - Cosmetology and Barber Examiners
Chapter 8 - Cosmetology Instructors and Instructor Trainees
Proposed Amendment - 20 CSR 2085-8.070 - Instructor Renewal and Inactive Licensee Requirements

Prepared April 3, 2013 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated savings of compliance with the amendment by affected entities:
1077	Instructor Licensees (Continuing Education Course Savings Savings Per Course Hour @ $68.00 to $92.00)	$73,236.00 to $99,084.00
	Estimated Annual Savings of Compliance for the Life of the Rule	**$73,236.00 to $99,084.00**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. Continuing education seminars are typically offered in twelve hour segments over two days. The cost of a two day seminar is $200 to $275 based upon a review of the registration fees of two major seminar providers. Since the number of hours is being decreased from twelve (12) to eight (8), there is a corresponding cost savings. For 2013, course providers offered 12 hours of instruction at costs ranging from $200 to $275 which yields per hour cost as follows: $200/12 =$17 per hour, $17x4=68, and $275/12=$23 per hour, $23x4=$92. Cost savings may vary from these estimates.
2. Travel expenses will vary based upon the distance the licensee must travel to the seminar location. Those costs have not been factored into the private costs. It is anticipated that the reduced number of required education hours and increased availability of course providers will reduce travel costs.
3. It is anticipated that the total savings will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2210—State Board of Optometry
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2210-2.030 License Renewal. The board is proposing to amend section (6) and subsection (11)(F).

PURPOSE: This amendment allows optometrists who obtain more than the required number of continuing education hours for license renewal to carry over some of those extra hours into the next renewal period and exempts newly licensed optometrists by examination from the continuing education requirement for their first renewal after initial licensure.

(6) Effective with the two**-** (2**-**)*[-]*year continuing education reporting period beginning on November 1, 2008, every optometrist currently licensed in Missouri shall obtain a minimum of thirty-two (32) hours of approved continuing education (herein "C.E." credits) relevant to the practice of optometry. **Any hours acquired beyond the required number may be carried forward into the next renewal period not to exceed sixteen (16) hours.**

(11) The following guidelines govern the attendance of educational optometric programs for license renewal:

(F) *[Individuals who take and pass Part III of the National Board of Examiners in Optometry (NBEO) examination in the first year of a two (2)-year reporting period are to be credited for sixteen (16) hours of continuing education towards his/her initial renewal. Individuals who take and pass Part III of the NBEO examination in the second year of a two (2)-year reporting period shall be exempt from the continuing education requirement for his/her initial renewal]* **Individuals who obtain a license by examination shall be considered to have satisfied the continuing education requirement for the first renewal after their initial license date**;

*AUTHORITY: sections 336.080 and 336.160.1, RSMo Supp. [2010] **2013**. This rule originally filed as 4 CSR 210-2.030. Original rule filed Dec. 19, 1975, effective Dec. 29, 1975. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 19, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Optometry, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-8216, or via email at optometry@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

PROPOSED AMENDMENT

22 CSR 10-1.010 General Organization. The Missouri Consolidated Health Care Plan is amending sections (2) and (5); deleting section (3); and renumbering as needed.

PURPOSE: This amendment removes the language regarding a chief operations officer from the rule as the chief operations officer is no longer a position at MCHCP.

(2) The responsibility for the proper operation of the plan and the direction of its policies is vested in a board of trustees. The administration of the detailed affairs of the plan is in the charge of an executive director*[, aided by a chief operations officer]*.

[(3) The chief operations officer shall perform duties as may be delegated to him/her by the executive director and in the absence or disability of the executive director shall perform the duties of the executive director.]

*[(4)]***(3)** The statutory provisions relating to the establishment and operation of the plan of health care benefits is provided for in Chapter 103, RSMo. The rules in 22 CSR 10-2 and 22 CSR 10-3 delineate the terms of the plan established by the trustees of the Missouri Consolidated Health Care Plan.

*[(5)]***(4)** Anyone wishing to obtain information may do so by contacting the plan at—

(A) 832 Weathered Rock Court, Jefferson City, MO 65101;
(B) PO Box 104355, Jefferson City, MO 65110;
(C) (573) 751-8881;
(D) (800) 701-8881; **or**
[(E) Email: mchcp@mchcp.org; or]
*[(F)]***(E)** Online: www.mchcp.org.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Dec. 16, 1993, effective July 30, 1994. Amended: Filed Dec. 19, 2003, effective June 30, 2004. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Amended: Filed Oct. 30, 2013.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

PROPOSED AMENDMENT

22 CSR 10-1.020 Public Records. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment clarifies MCHCP regular business hours.

(1) All public records of the Missouri Consolidated Health Care Plan, except for those records closed pursuant to the Health Insurance Portability and Accountability Act and section 610.021, RSMo, shall be open for inspection and copying at the plan's office during the

plan's regular business hours. The plan's regular business hours are 8:*[3]***0**0 a.m. until 4:30 p.m., Central Time **Monday through Friday, excluding state holidays**. All public meetings, records, votes, actions, and deliberation of the Missouri Consolidated Health Care Plan shall be open to the public, other than those meetings, records, and votes closed pursuant to provisions of section 610.021, RSMo.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Dec. 19, 2003, effective Aug. 30, 2004. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Amended: Filed Oct. 30, 2013.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is adding section (44); amending sections (27), (42), and (49); and renumbering as necessary.

PURPOSE: This amendment revises the term chemical dependency to substance use disorder, revises the definition of medically necessary, and adds the definition of Medicare Prescription Drug Plan (PDP).

(27) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/*[chemical dependency]* **substance abuse disorder** office visits;

(42) Medically necessary. **The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary** *[T]***t**reatments, procedures, services, or supplies that the plan administrator **or its designee** determines, in the exercise of its discretion **are**—

(A) *[Are e]***E**xpected to be of clear clinical benefit to the *[patient]* **member**; *[and]*

(B) *[Are appropriate for the care and treatment of the injury or illness in question; and]* **Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;**

(C) *[Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.]* **In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;**

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

(44) Medicare Prescription Drug Plan (PDP). The Medicare Prescription Drug Plan, administered by Express Scripts Medicare PDP is a Medicare Part D Plan with additional coverage to ensure Medicare members have similar benefits to non-Medicare members.

*[(44)]***(45)** Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

*[(45)]***(46)** Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

*[(46)]***(47)** Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

*[(47)]***(48)** Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

*[(48)]***(49)** Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.

*[(49)]***(50)** Participant. Shall have the same meaning as the term member defined herein (see member, section *[(44)]***(45)**.

*[(50)]***(51)** Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(51)]***(52)** Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

*[(52)]***(53)** Plan year. The period of January 1 through December 31.

*[(53)]***(54)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

*[(54)]***(55)** Premium. The monthly amount that must be paid for health insurance.

*[(55)]***(56)** Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

*[(56)]***(57)** Prior authorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan

will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.

*[(57)]***(58)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(19). Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

*[(58)]***(59)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(59)]***(60)** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

*[(60)]***(61)** Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.

*[(61)]***(62)** Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(62)]***(63)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(63)]***(64)** Specialty medications. High-cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(64)]***(65)** State. Missouri.

*[(65)]***(66)** Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(66)]***(67)** Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

*[(67)]***(68)** Subscriber. The employee or member who elects coverage under the plan.

*[(68)]***(69)** Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

*[(69)]***(70)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

*[(70)]***(71)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(71)]***(72)** Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

*[(72)]***(73)** Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

*[(73)]***(74)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(74)]***(75)** Vend**o**r. The current applicable third-party administrators of MCHCP benefits.

*[(75)]***(76)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5),

(8), (9), (10), and (12).

PURPOSE: This amendment revises language regarding the deadline for election of coverage for survivors, eligibility for new enrollments of disabled children over the age of twenty-six (26) years, leave of absence direct bill, transfer of coverage and reenrollment, and the time period COBRA disabled members may continue coverage; adds language regarding enrollment policy for employees, retirees, terminated vested subscribers, long-term disability subscribers and survivors who do not complete enrollment during the open enrollment period, the timeframe for reinstating medical coverage after a voluntary cancelation, claims processing for Medicare members and requirements for members to notify MCHCP of Medicare coverage; and removes language regarding the review of MCHCP's prescription drug plan and language regarding member enrollment in a Medicare Part D plan in addition to coverage under MCHCP because they are no longer applicable.

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. A retiree who returns to state employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

6. *[If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.]* **An employee who is eligible to continue coverage as a retiree must submit the Retiree Enrollment form at least thirty (30) days prior to the effective date of retirement.**

A. If the Retiree Enrollment form is not submitted thirty (30) days prior to the effective date of retirement the employee they shall not thereafter be eligible for coverage.

(C) Survivor Coverage.

1. At the time of the subscriber's death, a survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits from MOSERS or PSRS and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to subscriber's death. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. A survivor of a retiree or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the subscriber's death.

3. If a survivor adds a new spouse to his/her coverage and the survivor subsequently dies, the new spouse is no longer eligible for coverage.

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days *[of their eligibility date, they shall not thereafter be eligible for coverage]* **after the first day of the month following the death of the employee, s/he cannot enroll at a later date**.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a dependent, the active employee may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

4. If an employee is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the employee is currently enrolled in, effective the first day of the next calendar year.

A. If an employee is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If an employee is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

5. If an employee is currently enrolled in dental and/or vision coverage and does not complete open enrollment **to cancel coverage or change the current level of coverage** during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days with proof of prior medical coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the retiree is currently enrolled in, effective the first day of the next calendar year.

A. If a retiree is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a retiree is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

C. If a retiree is currently enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.

6. If a retiree is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a terminated vested subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a terminated vested subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a terminated vested subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to

MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a long-term disability subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a long-term disability subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a long-term disability subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor must submit a *[s]***S**urvivor *[e]***E**nrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor is currently enrolled in *[medical coverage]* **the PPO 300 or PPO 600 plan** and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the survivor is currently enrolled in, effective the first day of the next calendar year.

A. If a survivor is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If a survivor is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

5. If a survivor is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received.

(B) Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption listing subscriber as adoptive parent
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Government-issued death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, length of coverage, reason for coverage termination, and list of dependents covered
TRICARE Supplemental Coverage	Military ID Card
[Medicare]	*[Medicare Card]*

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled dependent or a currently enrolled permanently disabled dependent turning age twenty-six (26) **years** may continue coverage beyond age twenty-six (26) **years**, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the currently enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled dependent:

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26) **years**. Evidence could be from the Social Security Administration, representation from the dependent's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the Social Security Administration (SSA) confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) **years** is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends **or will never take effect for new enrollment requests.**

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

[(H) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not

be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.]

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the subscriber notifies MCHCP to cancel coverage.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

2. A subscriber may reinstate medical coverage after a voluntary cancelation by submitting an Enroll/Change/Cancel form prior to the end of current coverage.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, **Leave of Absence Enrollment** form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within ten (10) days of the date of the letter, coverage will continue**.** *[and t]***T**he employee will be set up on direct bill **unless the employee and affected dependents are transferred to the plan in which his/her spouse is enrolled**.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is terminated effective the last day of the month in which the employee is employed.

[3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.]

*[4.]***3.** If the employee's spouse is an active employee or retiree, the employee **and any covered dependents** may transfer *[coverage under]* to the plan in which the spouse is enrolled **if the transfer is elected on the Leave of Absence Enrollment form. Transfer is effective the first of the month following the date of leave**. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

*[5.]***4.** Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage *[in]* **with** MCHCP while on leave, may *[recommence]* **reenroll in** his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. **When a leave of absence employee returns to work and MCHCP receives a state contribution for the month s/he returned, s/he will be charged the active employee premium for that month.** For coverage to be reinstated, the employee must submit a completed **Enroll/Change/Cancel** form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

*[6.]***5.** If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents who have coverage due to the death of a non-vested employee may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) own expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage **and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage**, the member may continue coverage for up to *[twenty-nine (29)]* **an additional eleven (11)** months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(12) Medicare.

[(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.]

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(C) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65) years, the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10,

*1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (3), (4), and (5); and adding new section (4); and renumbering as necessary.

PURPOSE: This amendment revises the MCHCP contribution methodology for members retiring prior to July 1, 2012, the billing schedule and due dates for direct bill for Medicare primary Consolidated Omnibus Budget Reconciliation Act (COBRA), long-term disability, leave of absence, terminated vested and retiree and survivor members; and adds language regarding the methodology for the MCHCP contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan and the effect on coverage for non-payment of premium for Medicare primary subscribers.

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium **for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan** is based on *[creditable years of service at retirement with the state.]* **either of the following:**

(A) It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). For Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (3)(A) is compared to the flat dollar amount that was contributed for the same rate tier in 2002. The retiree's subsidy is the greater of the amount calculated in subsection (3)(A) or the flat dollar amount that was contributed in 2002.

(4) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (4)(A) is compared to fifty-two percent (52%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (4)(A) or fifty-two percent (52%) of the Medicare Prescription Drug Only Plan.

*[(4)]***(5)** Premium. Payroll deductions, Automated Clearing House (ACH) transactions, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes past-due premiums, the payroll deductions for current premiums along with the payroll deductions for past-due premiums will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars ($50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars ($51) to one hundred dollars ($100) will be deducted from two (2) payrolls;

C. One hundred one dollars ($101) to two hundred dollars ($200) will be deducted from three (3) payrolls;

D. Two hundred one dollars ($201) to three hundred dollars ($300) will be deducted from four (4) payrolls;

E. Three hundred one dollars ($301) to four hundred dollars ($400) will be deducted from five (5) payrolls;

F. Four hundred one dollars ($401) to five hundred dollars ($500) will be deducted from six (6) payrolls;

G. Five hundred one dollars ($501) to six hundred dollars ($600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars ($601) to seven hundred dollars ($700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars ($701) to eight hundred ($800) dollars will be deducted from nine (9) payrolls;

J. Eight hundred one dollars ($801) to nine hundred dollars ($900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars ($901) to one thousand dollars ($1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars ($1,001) and over will be deducted from twelve (12) payrolls.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums will be divided equally and taken from the subscriber's future payrolls as follows:

(I) One hundred dollars ($100) or less, deduction will be taken from one (1) payroll;

(II) One hundred one dollars ($101) to three hundred dollars ($300) will be deducted from two (2) payrolls;

(III) Three hundred one dollars ($301) to five hundred dollars ($500) will be deducted from three (3) payrolls;

(IV) Five hundred one dollars ($501) to seven hundred dollars ($700) will be deducted from four (4) payrolls;

(V) Seven hundred one dollars ($701) to nine hundred dollars ($900) will be deducted from five (5) payrolls; and

(VI) Nine hundred one dollars ($901) and over will be deducted from six (6) payrolls.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

2. If a retiree or survivor is currently having deductions taken from his/her benefit check and owes past-due premiums due to a change in his/her deductions, MCHCP will contact MOSERS to determine if the benefit check is large enough to cover the past-due premiums. If the benefit check is large enough to cover the past-due premiums, deductions will be divided and taken from the retiree or survivor's next three (3) benefit checks and coverage will be continuous. If the retiree or survivor's benefit check is not large enough to cover the deductions, and the retiree or survivor has failed to make the necessary premium payments, coverage will be terminated due to nonpayment, effective the last day of the month a full premium was received.

(D) Direct Bill for **non-Medicare** Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

[2. If a member is in arrears for two (2) months of premiums and payment is not received by the fifteenth of the second month for which premiums are due, coverage is terminated due to nonpayment on the last day of the month for which full premium was received. The member will be responsible for the value of the services rendered after the retroactive termination date (example: bill sent September 30 for October premiums and no payment received; bill mailed October 31 for October and November premiums due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30).]

(E) Direct Bill for Medicare Primary Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

*[(E)]***(F)** ACH Electronic Payment of Premiums for COBRA, Long-Term Disability, **Leave of Absence,** Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

2. If there are insufficient funds, MCHCP will send the *[member]* **subscriber** a letter and bill requesting payment. *[If a payment is in arrears, the direct bill timeline applies as defined in paragraph (4)(D)2.]*

*[(5)]***(6)** Premium Payments.

(A) By enrolling in coverage under MCHCP, a *[member]* **subscriber** agrees that MCHCP may deduct the member's contribution toward the total premium from the *[member's]* **subscriber's** paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending on the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the *[member's]* **subscriber's** payroll.

(B) MCHCP will automatically deduct the premium from the retiree or survivor's check. If the retiree or survivor's check is not sufficient to cover the retiree's or survivor's contribution toward total premium, the retiree or survivor will receive a monthly bill. A retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction from his/her retiree or survivor's check by contacting MCHCP.

1. If the retiree or survivor fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received.

2. If coverage terminates on the retiree, survivor, vested, or COBRA subscriber or his/her dependents, the subscriber cannot enroll in the plan at a later date. The subscriber is responsible for claims submitted after the termination date.

(C) If a *[member]* **non-Medicare subscriber** fails to pay premiums by the required due date, MCHCP allows a thirty-one- (31-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, *[the member]* **coverage** will be retroactively *[terminated to the date covered by the member's last paid premium.]* **terminated on the last day of the month for which full premium payment was received.** The *[member]* **subscriber** will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

(D) If a Medicare Primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends.

*[(6)]***(7)** Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period ending at the end of the month preceding the month during which notice of overpayment is received by MCHCP.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending subsection (1)(A).

PURPOSE: This amendment revises language regarding prior authorization for pharmacy services, the amount of time the member is given to submit additional documentation for prior authorizations, and removes language regarding the shingles vaccine.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) **years**, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service*[. Annual dollar limit may be exceeded with prior authorization]*;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care;

N. Hospice care and palliative services;

O. Hospital inpatient services except for observation stays;

P. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

Q. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

R. Nutritional counseling after three (3) sessions annually;

S. Orthognathic surgery;

T. Orthotics over one thousand dollars ($1,000);

U. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

V. Procedures with codes ending in "T";

W. Prostheses over one thousand dollars ($1,000);

X. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Y. Skilled nursing facility;

Z. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

AA. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services **included in the prescription drug plan for non-Medicare primary members** are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations;

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications; and

[G. Shingles vaccines prescribed by a physician.]

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least *[forty-five (45)]* **ninety (90)** calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**.*

Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (6), (7), and (8); adding new sections (5), and (11); and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, members who will have access to claim and payment information and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, out-of-pocket maximum amounts, how the subscriber is determined when both spouses are state employees, the percentage of usual, customary, and reasonable fees allowed, and timely filing of claims.

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family each calendar year, one thousand two hundred dollars ($1,200).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out-of-network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(C) Network out-of-pocket maximum for individual—*[one thousand two hundred dollars ($1,200)]* **one thousand three hundred seventy-five dollars ($1,375)**.

(D) Network out-of-pocket maximum for family—*[two thousand four hundred dollars ($2,400)]* **two thousand seven hundred fifty dollars ($2,750)**.

(E) Non-network out-of-pocket maximum for individual—*[two thousand four hundred dollars ($2,400)]* **two thousand seven hundred fifty dollars ($2,750)**.

(F) Non-network out-of-pocket maximum for family—*[four thousand eight hundred dollars ($4,800)]* **five thousand five hundred dollars ($5,500)**.

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: *[copayments;]* charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed amount for transplants performed by a non-network provider.

(4) Married, active employees who are MCHCP subscribers *[need to]* **and have enrolled children may** meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. *[Each subscriber will have access to all claim and payment information of the family unit.]* **In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber.** Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

*[(6)]***(7)** Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible *[or out-of-pocket maximum]*.

(A) Office visit—primary care: twenty-five dollars ($25); specialist: forty dollars ($40); chiropractor **office visit** and/or manipulation: twenty dollars ($20); urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the *[deductable]* **deductible** and coinsurance.

1. Vision office visit or refraction: forty dollars ($40);

2. Hearing test—performed by a primary care provider: twenty-five dollars ($25); performed by a specialist: forty dollars ($40).

(B) Emergency room—two hundred dollars ($200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.

*[(7)]***(8)** Usual, customary, and reasonable fee allowed—non-network medical claims are allowed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(8)]***(9)** Any claim must be **initially** submitted within twelve (12)

months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(9)]***(10)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(11) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities four hundred twenty-one thousand dollars ($421,000) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
23,538	**Subscribers enrolled in PPO 300 for CY 2014**	**$421,000**

III. WORKSHEET

Estimated cost is the projected increase in the subscriber's share of non-network paid claims for calendar year 2014 due to MCHCP's share going from 85 percent to 80 percent of usual, customary and reasonable (UCR) charges for non-network claims. The estimated cost is calculated by multiplying total net paid for non-network PPO 300, 2012 claims by five percent.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Calendar year 2014 costs for non-network claims will remain relatively stable;

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (4), (6), and (7); adding new sections (5) and (10); and renumbering as needed.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding how the subscriber is determined when both spouses are state employees, the percentage of usual, customary, and reasonable fees allowed, and timeframe for filing claims.

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars ($600); family each calendar year, one thousand two hundred dollars ($1,200). Non-network: per individual each calendar year, one thousand two hundred dollars ($1,200); family each calendar year, two thousand four hundred dollars ($2,400).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out-of-network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(4) Married, active employees who are MCHCP subscribers *[need to]* **and have enrolled children may** meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. *[Each subscriber will have access to all claim and payment information of the family unit.]* **In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber.** Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

*[(6)]***(7)** Usual, customary, and reasonable limit fee allowed—non-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(7)]***(8)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(8)]***(9)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(10) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities five hundred seventy-three thousand dollars ($573,000) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
28,151	**Subscribers enrolled in PPO 600 for CY 2014**	**$573,000**

III. WORKSHEET

Estimated cost is the projected increase in the subscriber's share of non-network paid claims for calendar year 2014 due to MCHCP's share going from 85 percent to 80 percent of usual, customary and reasonable (UCR) charges for non-network claims. The estimated cost is calculated by multiplying total net paid for non-network PPO 600, 2012 claims by five percent.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Calendar year 2014 costs for non-network claims will remain relatively stable;

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), (6), (10), and (12); and adding new sections (5) and (9); and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, coinsurance, and out-of-pocket maximum amounts, the percentage of usual, customary, reasonable fees allowed, timeframes for filing claims, plan choices when a member becomes Medicare eligible, and the timing of health savings account (HSA) contributions.

(1) Deductible amount—Network: per individual each calendar year, *[one thousand two hundred fifty dollars ($1,250)]* **one thousand six hundred fifty dollars ($1,650)**; family each calendar year, *[two thousand five hundred dollars ($2,500)]* **three thousand three hundred dollars ($3,300)**. Non-network: per individual each calendar year, *[two thousand five hundred dollars ($2,500)]* **four thousand dollars ($4,000)**; family each calendar year, *[five thousand dollars ($5,000)]* **eight thousand dollars ($8,000)**.

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Out-of-pocket maximum—*[t]***T**he maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(C) Network out-of-pocket maximum for individual—*[two thousand five hundred dollars ($2,500)]* **three thousand three hundred dollars ($3,300)**.

(D) Network out-of-pocket maximum for family—*[five thousand dollars ($5,000)]* **six thousand six hundred dollars ($6,600)**.

(4) Married, active employees who are MCHCP subscribers *[need to]* **and have enrolled children may** meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must **provide the other spouse's Social Security Number (SSN) and** report the other spouse as eligible for coverage when newly hired and during the open enrollment process. *[Each subscriber will have access to all claim and payment information of the family unit.]* **In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber.** Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred.]* **following the date of service.** The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(6)]***(7)** Usual, customary, and reasonable fee allowed—*[n]***N**on-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(7)]***(8)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(9) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*[(8)]***(10)** A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (11) of this *[regulation]* **rule**, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

*[(9)]***(11)** A retiree becoming eligible for Medicare in the upcoming plan year may not enroll in the HDHP during open enrollment.

*[(10)]***(12)** If a subscriber is enrolled in the HDHP and his/her status changes to Medicare primary during the plan year, the subscriber must *[choose another plan]* **enroll in the PPO 300 Plan or PPO 600 Plan** within thirty-one (31) days of notice from MCHCP or if no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan. A new plan deductible and out-of-pocket maximum will apply.

*[(11)]***(13)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(12)]***(14)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must **be an active employee and** open an HSA with the bank designated by MCHCP.

(B) The MCHCP contributions will be deposited into the subscriber's HSA bi-annually **on the Friday after the first Thursdays in January and July** as follows:

[Deposit]	Subscriber Only	All other coverage levels
[January 4, 2013]	$150.00	$300.00
[July 5, 2013]	$150.00	$300.00

(C) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP bi-annual contributions will receive a prorated bi-annual contribution. A subscriber will not be able to voluntarily change his/her plan selection after the bi-annual contribution has been deposited into the subscriber's HSA.

(D) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP bi-annual contribution will receive a prorated bi-annual contribution based on the increased level of coverage.

(E) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution for a future month(s), MCHCP will not request a re-payment of the contribution(s).

(F) If both a husband and wife are state employees covered by MCHCP and they both enroll in an HDHP with HSA, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a three hundred dollar ($300) contribution to each spouse to total six hundred dollars ($600).

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities two thousand eight hundred dollars ($2,800) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
1,814	**Subscribers enrolled in HDHP for CY 2014**	**$2,800**

III. WORKSHEET

Estimated cost is the projected increase in the subscriber's share of non-network paid claims for calendar year 2014 due to MCHCP's share going from 85 percent to 80 percent of usual, customary and reasonable (UCR) charges for non-network claims. The estimated cost is calculated by multiplying total net paid for non-network HDHP, 2012 claims by five percent.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Calendar year 2014 costs for non-network claims will remain relatively stable;

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RESCISSION

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded as the Medicare Supplement Plan Benefit offered by Missouri Consolidated Health Care Plan (MCHCP) is no longer available.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Rescinded: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RESCISSION

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Rescinded: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

(1) Benefit Provisions Applicable to the PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension; or
7. Depression with one (1) other disease management condition.

(B) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension with one (1) other disease management condition; or
7. Depression with one (1) other disease management condition.

(C) A member identified as eligible for disease management through medical and prescription drug claims will receive an invitation to participate.

(4) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or
(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or
(II) Drugs when all of the following are met:
(a) History of allergy to a particular drug;
(b) There is no effective alternative drug; and
(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
(II) Food allergy;
(III) Hymenoptera venom allergy (stinging insects);
(IV) Inhalant allergy; or
(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;
(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
(III) Thymoma; and
(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;
(II) Dust mite atopic dermatitis;
(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: The following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test sentences (HINT), and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multi-syllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

23. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status; and

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. The professional fee for automated lab work is not a covered service;

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier

than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborn will be subject to coinsurance and deductible if mother is not covered under the plan;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Rescinded and readopted: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions $391,111,200 in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $116,856,228 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$391,111,200**

III. WORKSHEET

Estimated cost is the annual MCHCP contribution toward premiums for providing health care plans to enrolled employees, retirees and dependents for calendar year 2014. Calculated by multiplying total enrollment as of July 1, 2013 under each applicable rate tier by the MCHCP's share of the total premium equivalent rates for each rate tier to determine the estimated cost based on the assumptions below.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Used calendar year 2014 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- The costs projected are for the MCHCP's share of the premium. Actual claim costs vary based upon utilization of services but the premium (both MCHCP's and subscriber's share of the premium) is projected to cover claim costs.

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
96,248 individuals enrolled in MCHCP plans for CY 2014	**Individuals enrolled in MCHCP plans for CY 2014**	**$116,856,228**

III. WORKSHEET

Estimated cost is the annual MCHCP subscribers' premiums for calendar year 2014. Calculated by multiplying total enrollment as of July 1, 2013 under each applicable rate tier by the subscriber's share of the total premium equivalent rates for each rate tier to determine the estimated cost based on the assumptions below.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Used calendar year 2014 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- The costs projected are for the subscriber's share of the premium. Actual claim costs vary based upon utilization of services but the premium (both MCHCP's and subscriber's share of the premium) is projected to cover claim costs.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering the rest of the sections as subsections as necessary.

PURPOSE: This amendment revises language regarding acts of war, alternative therapies, and custodial or domiciliary care; and adds language regarding charges exceeding vendor contracted rates or benefit limits, cosmetic procedures, bundled devices or supplies, telehealth, and therapies.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein*[.]* **or in 22 CSR 10-2.055.**

*[(2)]***(A)** Abortion*[—other than situations where]* **unless** the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

*[(3)]***(B)** Acts of war **including**—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

*[(4)]***(C)** Alternative therapies—**that are outside conventional medicine** including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

*[(5)]***(D)** Assistive listening device.

*[(6)]***(E)** Assistant surgeon services—*[not covered]* unless determined to meet the clinical eligibility for coverage under the plan.

*[(7)]***(F)** Athletic *[trainer]* **training** services*[—services by a licensed athletic trainer not covered]*.

*[(8)]***(G)** Autopsy.

*[(9)]***(H)** Birthing center.

*[(10)]***(I)** Blood donor expenses*[—not covered]*.

*[(11)]***(J)** Blood pressure cuffs/monitors*[—not covered]*.

*[(12)]***(K)** Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

*[(13)]***(M)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(14)]***(N)** Childbirth classes.

*[(15)]***(O)** Comfort and convenience items.

(P) Cosmetic procedures.

*[(16)]***(Q)** Custodial or domiciliary care—*[includes]* **including** services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be *[provided]* **performed** by persons *[without the training of a health care provider]* **who are not providers**.

(R) Devices or supplies bundled as part of a service are not separately covered.

*[(17)]***(S)** Educational or psychological testing*[—not covered]* unless part of a treatment program for covered services.

*[(18)]***(T)** Examinations requested by a third party.

[(19) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.]

*[(20)]***(U)** Exercise equipment.

*[(21)]***(V)** Experimental *[services]* or investigational services*[—experimental or investigational services]*, procedures, supplies, or drugs as determined by the claims administrator *[are not covered]*.

*[(22)]***(W)** Eye services*[—health services]* and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(23)]***(X)** Services obtained at a government facility*[—not covered]* if care is provided without charge.

*[(24)]***(Y)** Gender reassignment*[—health]* services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

*[(25)]***(Z)** Health and athletic club membership—including costs of enrollment.

*[(26)]***(AA)** Home births.

*[(27)]***(BB)** Immunizations requested by third party *[or for travel]*.

*[(28)]***(CC)** Infertility treatment*[. Services are]* **beyond the** covered **services** to diagnose the condition.

*[(29)]***(DD)** Level of care, *[if]* greater than is needed for the treatment of the illness or injury.

*[(30)]***(EE)** Long-term care.

*[(31)]***(FF)** Maxillofacial surgery.

*[(32)]***(GG)** Medical care and supplies*[—not covered]* to the extent that they are payable under—

*[(A)]***1.** A plan or program operated by a national government or one (1) of its agencies; or

*[(B)]***2.** Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(33)]***(HH)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(34)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(35)]***(JJ)** Never events—*[twenty-eight (28)]* **never events are twenty-nine (29)** occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. *[They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.]*

*[(36)]***(KK)** Nocturnal enuresis alarm.

*[(37)]***(LL)** Not medically-necessary services.

*[(38)]***(MM)** Orthoptics.

*[(39)]***(NN)** Other charges **as follows:**

1. *[—no coverage for charges]* **Charges** that would not **otherwise** be incurred if the subscriber was not covered **by the plan***[.]***;**

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted*[.]***;**

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan*[.]***; and**

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

*[(40)]***(OO)** Over-the-counter medications with or without a prescription including but not limited to analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(41)]***(PP)** Physical fitness.

*[(42)]***(QQ)** Private-duty nursing.

*[(43)]***(RR)** Self-inflicted injuries—not covered unless related to a mental diagnosis.

*[(44)]***(SS)** Sex therapy.

*[(45)]***(TT)** Surrogacy—pregnancy coverage is limited to plan member.

(UU) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(VV) Therapy. Physical, occupation, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic performance or for recreation;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training;

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(46)]***(WW)** Travel expenses*[—not covered except for transplants in a transplant network facility:]*.

*[(47)]***(XX)** Workers' Compensation*[—charges for]* services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is deleting subsection (4)(B).

PURPOSE: This amendment removes language regarding the MCHCP Medicare Supplement Plan which is no longer available.

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

[(B) In the event that MCHCP is a secondary plan as to one (1) or more plans, the benefits of MCHCP's Medicare Supplement Plan may be reduced so as not to exceed the amount due to the provider after the benefits of the other plan have been applied. MCHCP will compare what it would have paid in absence of this COB provision to the remainder due after the benefits of the other plan were applied and pay up to what it would have paid but not more than is due the provider.]

*AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (4), and (6), and adding a new section (7).

PURPOSE: This amendment revises the services applicable to this rule, the addresses and phone numbers to direct appeals, and the guidelines under which the Board of Trustees and/or staff may grant an appeal.

(2) Claims Submissions and Initial Benefit Determinations **for Medical and Non-Medicare Primary Pharmacy Services**.

(3) General Appeal Provisions **for Medical and Non-Medicare Primary Pharmacy Services**.

(4) Appeal Process for Medical and **Non-Medicare Primary** Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
[8320 Ward Parkway] **9401 Indian Creek Parkway, Suite 1300**
[Kansas City, MO 64114] **Overland Park, KS 66210**

(b) Expedited appeals must be communicated by calling *[(816) 221-8400]* **(913) 202-5000** or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route *[0390]* **BL0390**
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

[Office of Consumer Information and
Oversight
Department of Health and Human Services
PO Box 791
Washington, DC 20044
or by fax to (202) 606-0036
or by email to disputedclaim@opm.gov]
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number *[(877) 549-8152]* **(888) 866-6205** with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines*[.]***:**

[(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's birth date.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contributions has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(I) Loss of coverage notice—MCHCP may approve a late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) Wellness participation—MCHCP may deny all appeals regarding continuation of participation in the Strive for Wellness Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30)

days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.]

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the initial request is made in writing to the board of trustees within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal for the request to be considered;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected during the annual open enrollment period if the request is made within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. The subscriber must include payment in full for all past and current premiums due for reinstatement;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve an appeal to change a subscriber's medical plan coverage level prospectively, if the appeal is received within the first thirty (30) days of the start of coverage, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contributions has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(H) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is timely from date of late notice;

(I) MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period;

(J) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline;

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; and

(M) MCHCP may approve appeals of a late submission of a Preventive Lab form if the subscriber can provide substantiating evidence that the preventive lab screening was received timely, that the subscriber reasonably relied on the health care provider to submit the Preventive Lab form to the wellness vendor, and the health care provider failed to submit the Preventive Lab form to the wellness vendor prior to the May 31 due date.

(7) Medicare Primary Pharmacy Appeals.

(A) Appeals rights and procedures for Medicare primary pharmacy services are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Pharmacy Employer Group Waiver Plan vendor, Express Scripts, for additional information on appeal rights and procedures.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for Medicare-primary members of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as

regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) The following Medicare primary members enrolled in the PPO 300, PPO 600, or the Medicare Prescription Drug Only Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan:

1. Active employee members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage.

(B) The non-Medicare primary dependents of Medicare primary members will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(C) Foster parent members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(D) A retiree Medicare primary member who chooses not to be in the Medicare Prescription Drug Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical or Medicare Prescription Drug Plan at a later date.

(E) MCHCP will pay the Medicare financial penalty incurred by a Medicare primary member who has had a continuous gap in prescription drug coverage of sixty-three (63) days or more after the Medicare Initial Election Period (IEP) and was not covered by any creditable prescription drug coverage and failed to enroll into Part D.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicare Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach two thousand eight hundred fifty dollars ($2,850), the member will pay the following copayments:

A. Generic Formulary Drugs: thirty-one- (31-) day supply has an eight dollar ($8) copayment; sixty- (60-) day supply has a sixteen dollar ($16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar ($24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar ($20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar ($35) copayment; sixty- (60-) day supply has a seventy dollar ($70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar ($105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent ($87.50) copayment; and

C. Non-preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment.

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed two thousand eight hundred fifty dollars ($2,850) and remain below four thousand five hundred fifty dollars ($4,550), the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach four thousand five hundred fifty dollars ($4,550);

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach four thousand five hundred fifty dollars ($4,550), the member will pay the greater of—

A. Five percent (5%) coinsurance or a two dollar and fifty-five cent ($2.55) copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or a six dollar and thirty-five cent ($6.35) copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

(G) Medications covered under 22 CSR 10-2.090 will be covered under the Medicare Prescription Drug Plan as Non-Part D medications when they are not a Part D covered drug.

(H) Medicare Part B Prescription Drugs. For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:

1. Diabetes testing and maintenance supplies;
2. Respiratory agents;
3. Immunosuppressants; and
4. Oral anti-cancer medications.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Original rule filed Oct. 30, 2013.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions $11,277,915 in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $12,344,457 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	**22 CSR 10-2.089 Pharmacy Benefits for Medicare Primary Members**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$11,277,915**

III. WORKSHEET

Estimated cost is the annual estimated state contribution for the pharmacy portion of the premium for Medicare primary subscribers for calendar year 2014. Calculated by multiplying Medicare primary subscriber enrollment as of July 1, 2013 under each applicable rate tier by the MCHCP's share of the pharmacy portion of the total premium equivalent rates for each rate tier to determine the estimated cost based on the assumptions below.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Used calendar year 2014 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- The costs projected are for the MCHCP's share of the pharmacy portion of the premium. Actual claim costs vary based upon utilization of services but the premium (both MCHCP's and subscriber's share of the premium) is projected to cover claim costs.

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.089 Pharmacy Benefits for Medicare Primary Members**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
12,422 Medicare primary individuals enrolled in MCHCP plans for CY 2014	**Medicare primary individuals enrolled in MCHCP plans for CY 2014**	**$12,344,457**

III. WORKSHEET

Estimated cost is the annual MCHCP Medicare primary subscriber's pharmacy portion of the premium for calendar year 2014. Calculated by multiplying total enrollment as of July 1, 2013 under each applicable rate tier by the Medicare primary subscriber's share of the total premium equivalent rates for each rate tier to determine the estimated cost based on the assumptions below.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable;
- Used calendar year 2014 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- The costs projected are for the Medicare primary subscriber's share of the premium. Actual claim costs vary based upon utilization of services but the premium (both MCHCP's and subscriber's share of the premium) is projected to cover claim costs.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (8), deleting section (7), adding a new section (9), and renumbering as necessary.

PURPOSE: This amendment revises language regarding coverage for prescription drugs for non-Medicare primary members; PPO 300 and PPO 600 plan member copayments, home delivery days supply, and maintenance prescription fill selection; prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine and contraception covered at one hundred percent (100%); HDHP with HSA plan coinsurance, home delivery days supply, maintenance prescription fill selection, prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine and contraception covered at one hundred percent (100%); and formulary updates and quantity level limits. This amendment adds language regarding compound drug copayments and out-of-pocket maximum amounts for members enrolled in the PPO 300 and PPO 600 plans; and removes language regarding Medicare Part B prescriptions coordination of coverage.

(1) The pharmacy benefit provides coverage for prescription drugs*[. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician]* **to non-Medicare primary members**.

(A) PPO 300*[,]* **and** PPO 600*[, and Medicare Supplement Plan Prescription Drug Coverage]*.

1. Network:

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply** for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply** for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply** for a drug not on the formulary;

D. Home delivery program*[—]***.**

(I) Maintenance prescriptions may be filled through the home delivery program *[or through a retail pharmacy that has agreed to fill maintenance prescriptions at a comparable price to the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits]*.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

[(II) Select home delivery—]

*[(a)]***(d)** A member must choose how *[s/he will fill his/her]* maintenance prescription*[(]*s*[). A member must]* **will be filled by** notif*[y]***ing** the pharmacy benefit manager **(PBM)** of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

*[(b)]***I.** If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the *[pharmacy benefit manager]* **PBM** of his/her decision, the first two (2) maintenance prescription orders *[can]* **may** be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the *[pharmacy benefit manager]* **PBM** of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. *[Once the pharmacy benefit manager has been notified of the member's decision to purchase his/her maintenance prescription(s) through a retail pharmacy, the retail election remains in place for one (1) year. After one (1) year, the member will be required to make a choice between home delivery and retail pharmacy for maintenance prescriptions]* **If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision**; and

*[(c)]***II.** Once a member makes his/her delivery *[election]* **decision**, the member can modify *[his/her election]* **the decision** by contacting the *[pharmacy benefit manager]* **PBM**; and

*[(III)]***(II)** Specialty drugs **are** covered only through *[network]* **the specialty** home delivery **network** for up to thirty-**one-** *[(30-)]* **(31-)** day*[s]* **supply**. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayment: Eight dollars ($8) for a generic drug on the formulary list.

(b) Brand copayment: Thirty-five dollars ($35) for a brand drug on the formulary.

(c) Non-formulary copayment: One hundred dollars ($100) for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix;

*[F.]***G.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[G.]***H.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug; and

*[H.]***I.** *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%), as prescribed by a physician and included on the formulary through the pharmacy benefit manager.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less the applicable copayment.

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

3. Out-of-pocket maximum. The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

A. Network and non-network out-of-pocket maximums are not separate;

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount;

C. Individual—six thousand two hundred fifty dollars ($6,250);

D. Family—twelve thousand dollars ($12,000).

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network:

A. Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

B. Brand: Twenty percent (20%) coinsurance after deductible **has been met** for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

C. Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. *[Some medications may not qualify for the program because they require prior authorization or quantity level limits.]*

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(b) Brand: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs covered only through network home delivery for up to thirty-**one-** *[(30-)]* **(31-)** days.

(a) Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a generic drug on the formulary*[.]***;**

(b) Brand: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a brand drug on the formulary*[.]***;**

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary; *[and]*

E. *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other, more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first-step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the physician may request a prior authorization from the *[pharmacy benefit manager]* **PBM**. If the prior authorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(3) Disease Management **(DM)** Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the *[Disease Management]* **DM** Program and enrolled in the PPO 300 Plan or PPO 600 Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the *[Disease Management]* **DM** Program when s/he is enrolled in a *[Disease Management]* **DM** Program through the medical plan vendor and one (1) of the following:

1. Is working one-on-one with a **DM** nurse; *[or]*

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a **DM** nurse until **the medical plan vendor determines** the condition *[is]* **can be** managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a **DM** nurse.

(4) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. *[Members]* **A member** may request **a** claim form*[s]* from the plan or the *[pharmacy benefit manager]* **PBM**. In order to file a claim, **the** member*[s]* must—

(C) *[Members]* **A member** must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less any applicable copayment, deductible, or coinsurance. *[Members are]* **A member is** responsible for any charge over the network discounted price and the applicable copayment.

(5) Formulary*[—]***.** The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; *[or]*

(C) A drug is determined to have a safety issue **by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer under the pharmacy benefit**.

[(7) Medicare Part B Prescription Drugs—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

(A) Diabetes testing and maintenance supplies;

(B) Respiratory agents;

(C) Immunosuppressants; and

(D) Oral anti-cancer medications.]

*[(8)]***(7)** Quantity Level Limits*[—]***.** Quantities of some medications may be limited based on recommendations by the *[Food and Drug Administration and]* **FDA or credible scientific evidence published in peer-reviewed** medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

*[(9)]***(8)** Guidelines for Drug Use*[—]***.** If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.

(9) Affordable Care Act (ACA) required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending subsections (5)(D), (7)(A), and (8)(A).

PURPOSE: This amendment revises language regarding coverage termination for dependents over the age of twenty-six (26) years, voluntary cancellation of coverage, and continuation of coverage for

Consolidated Omnibus Budget Reconciliation Act (COBRA) members.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received.

(D) Disabled Dependent.

1. A newly eligible foster parent may enroll his/her permanently disabled dependent or a currently enrolled permanently disabled dependent turning age twenty-six (26) **years** may continue coverage beyond age twenty-six (26) **years**, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the currently enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new foster parent and his/her permanently disabled dependent:

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26). Evidence could be from the Social Security Administration (SSA), representation from the dependent's physician, or by sworn statement from the subscriber.

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) **years** is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends **or never take effect for new enrollment requests**.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(7) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the subscriber notifies MCHCP to cancel coverage.

1. A subscriber may reinstate medical coverage after a voluntary cancelation by submitting an Enroll/Change/Cancel form prior to the end of current coverage.

(8) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible foster parents and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated eligible foster parents and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Eligible foster parents voluntarily or involuntarily ending licensure as a foster parent (for reasons other than gross misconduct) may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered foster parent becomes eligible for Medicare.

4. A surviving spouse and dependents, who have coverage due to the death of an eligible foster parent, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage **and the disability continues during the rest of the initial eighteen (18) month period of continuation of coverage**, the member may continue coverage for up to *[twenty-nine (29)]* **an additional eleven (11)** months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. [2012] **2013**. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.140 Wellness Center Provisions, Charges, and Services

PURPOSE: This rule establishes the policy of the board of trustees in regard to provisions, charges, and services available to members of the Missouri Consolidated Health Care Plan (MCHCP) through the MCHCP Wellness Center.

(1) Eligibility. Active employees enrolled in an MCHCP medical plan shall be eligible for and able to access the services available at the wellness center as described in this rule.

(2) Available Services. The wellness center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(A) Sore throats/ears/headache;
(B) Strains/sprains/musculoskeletal problems;
(C) Non-specific abdominal pain;
(D) Non-specific chest pain;
(E) Cough;
(F) Sinus conditions;
(G) Allergy injections;
(H) Hormone injections;
(I) Immunizations including immunization for influenza;
(J) Biometric screenings;
(K) Rashes;
(L) Acute urinary complaints;
(M) Personal hygiene related problems;
(N) Acute injuries/acute routine office procedures;
(O) Emergency First-Response for worksite injuries;
(P) Minor surgical procedures, such as sutures for laceration treatment;
(Q) Ordinary and routine care of the nature of a visit to the doctor's office;
(R) Treatment and monitoring of diabetes and hypertension; and
(S) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.

(3) Limitations and Exclusions.
(A) The following employees are not eligible for the wellness center:
1. Active employees who are not enrolled in an MCHCP medical plan;
2. Dependents of active employees; and
3. Retirees and their dependents.
(B) Services that are beyond the scope of practice of the wellness center including, but not limited to, the following:
1. Emergency services;
2. Urgent care services;
3. Radiology services;
4. Specialist services;
5. Pharmacy services;
6. Occupational, speech, and physical therapy services; and
7. Chiropractic services.

(4) Charges for the following services apply:
(A) Office visit—
1. For active employees enrolled in the MCHCP PPO 300 or PPO 600 Plan, fifteen dollars ($15) payable at the time of service;
2. For active employees enrolled in the High Deductible Health Plan, forty-five dollars ($45) payable at the time of service; and
3. The office visit includes the evaluation and management of the patient and any associated laboratory services.
(B) Preventive care—
1. For active employees enrolled in the MCHCP PPO 300 Plan, PPO 600 Plan, or High Deductible Health Plan, preventive care is covered at one hundred percent (100%); and
2. Preventive care shall have the same meaning as in 22 CSR 10-2.055.
(C) Wellness center services are outside the MCHCP PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan benefits and payments for center services do not apply toward any associated deductible or out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Original rule filed Oct. 30, 2013.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities one hundred nineteen thousand three hundred ninety-six dollars ($119,396) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.140 Wellness Center Provisions, Charges, and Services**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
96,373 individuals enrolled in MCHCP plans for CY 2013	**Individuals enrolled in MCHCP plans for CY 2014**	**$119,396**

III. WORKSHEET

Estimated cost is the amount collected from projected number of user visits of the center multiplied by the cost of each visit ($15 PPO-enrolled users and $45 for HDHP-enrolled users).

IV. ASSUMPTIONS

- Assumed utilization for PPO-enrolled users is that 30 percent of PPO-enrolled eligibles in the area will use the wellness center.
- Assumed utilization for HDHP-enrolled users is that 25 percent of HDHP-enrolled eligibles in the area will use the wellness center.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending section (41).

PURPOSE: This amendment revises the term chemical dependency to substance use disorder and revises the definition of medically necessary.

(27) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/*[chemical dependency]* **substance abuse disorder** office visits;

(41) Medically necessary. **The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary** *[T]***t**reatments, procedures, services, or supplies that the plan administrator **or its designee** determines, in the exercise of its discretion **are**—

(A) *[Are e]***E**xpected to be of clear clinical benefit to the *[patient]* **member**; *[and]*

(B) *[Are appropriate for the care and treatment of the injury or illness in question; and]* **Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;**

(C) *[Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.]* **In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;**

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (5), (8), (9), and (10); and renumbering as necessary.

PURPOSE: This amendment revises language regarding eligibility for new enrollments of disabled children over the age of twenty-six (26) years and the time period COBRA disabled members may continue coverage; and adds the timeframe for reinstating medical coverage after a voluntary cancelation.

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is fully vested in the retirement plan upon termination and the public entity remains with MCHCP. The public entity must make the benefits available to all retirees, past and future, who meet the vesting requirements. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If the retiree's spouse is an active public entity employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

3. A retiree who returns to employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

4. *[If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.]* **An employee who is eligible to continue coverage as a retiree must submit the Retiree Enrollment form at least thirty (30) days prior to the effective date of retirement.**

A. If the Retiree Enrollment form is not submitted thirty (30) days prior to the effective date of retirement the employee shall not thereafter be eligible for coverage.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled dependent or a currently enrolled permanently disabled dependent turning age twenty-six (26) **years and** may continue coverage beyond age twenty-six (26) **years**, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the currently enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled dependent:

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26) **years**. Evidence could be from the Social Security Administration, representation from the dependent's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the Social Security Administration (SSA) confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) **years** is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends **or never take effect for new enrollment requests**.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP to cancel coverage.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the cafeteria plan.

2. A subscriber may reinstate medical coverage after a voluntary cancelation by submitting an Enroll/Change/Cancel/Waive form prior to the end of current coverage.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing public entity must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is terminated effective the last day of the month in which the employee is employed.

[3. If the employee fails to pay the premium due to the public entity, coverage on the employee and his/her dependents terminates.]

*[4.]***3.** If the employee's spouse is an active employee or retiree, the employee may transfer coverage under the plan in which the spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

*[5.]***4.** Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed **Enroll/Change/Cancel/Waive** form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

*[6.]***5.** If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents who have coverage due to the death of a non-vested employee may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) own expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage **and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage**, the member may continue coverage for up to *[twenty-nine (29)]* **an additional eleven (11)** months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises language regarding the amount of time the member is given to submit additional documentation for prior authorizations and removes language regarding the shingles vaccine.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) **years**, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service*[. Annual dollar limit may be exceeded with prior authorization]*;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care;

N. Hospice care and palliative services;

O. Hospital inpatient services except for observation stays;

P. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

Q. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

R. Nutritional counseling after three (3) sessions annually;

S. Orthognathic surgery;

T. Orthotics over one thousand dollars ($1,000);

U. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

V. Procedures with codes ending in "T";

W. Prostheses over one thousand dollars ($1,000);

X. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Y. Skilled nursing facility;

Z. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

AA. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; **and**

F. Medication with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications*[; and]***.**

[G. Shingles vaccines prescribed by a physician.]

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least *[forty-five (45)]* **ninety (90)** calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (6); adding new sections (5) and

(9), and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, who will have access to claim and payment information and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, copayment, and out-of-pocket maximum amounts, the percentage of usual, customary, and reasonable fees allowed, and timely filing of claims.

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family each calendar year, six thousand dollars ($6,000).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Copayments—set charges for the following services apply as long as network providers are utilized unless otherwise specified. Copayments do not apply to the deductible *[or out-of-pocket maximum]*.

(A) Office visit—*[Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.]* **Office visit—primary care: twenty-five dollars ($25); specialist: forty dollars ($40); chiropractor office visit and/or manipulation: twenty dollars ($20); urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance**.

1. Vision office visit or refraction—*[thirty dollars ($30)]* **forty dollars ($40)**.

2. Hearing test—performed by a primary care physician: *[twenty dollars ($20)]* **twenty-five dollars ($25)**; performed by a specialist: *[thirty dollars ($30)]* **forty dollars ($40)**.

[(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; one hundred percent (100%) coverage for routine prenatal office visits and recommended screenings; lab—covered at one hundred percent (100%); other services and diagnostic tests—ninety percent (90%) coinsurance after deductible; Non-network: all services paid at seventy percent (70%) coinsurance after deductible.]

*[(C)]***(B)** Emergency room—*[Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).]* **two hundred dollars ($200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.**

[(D) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(E) Bariatric surgery—five hundred dollar ($500) copayment and ten percent (10%) coinsurance after deductible is met.]

(4) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(D) Network out-of-pocket maximum for family—*[thirteen thousand five hundred dollars ($13,500)]* **twelve thousand five hundred dollars ($12,500)**.

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: *[copayments;]* charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed amount for transplants performed by a non-network provider.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(6)]***(7)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(7)]***(8)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(9) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities four thousand six hundred four dollars and thirty-six cents ($4,604.36) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the

Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
299	**Subscribers enrolled in PPO 1000 for CY 2014**	**$ 4,604.36**

III. WORKSHEET

Estimated cost is the projected increase in the subscriber's share of non-network paid claims for calendar year 2014 due to the MCHCP's share going from 85 percent to 80 percent of usual, customary and reasonable (UCR) charges for non-network claims. The estimated cost is calculated by multiplying total net paid for non-network PPO 1000, 2012 claims by five percent.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable
- Calendar year 2014 costs for non-network claims will remain relatively stable

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RESCISSION

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded as the PPO Plan Benefit offered by Missouri Consolidated (MCHCP) is no longer available.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Rescinded: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), and (5); adding new sections (4) and (10); and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding member contributions toward the deductible, coinsurance, and out-of-pocket maximum amounts, the percentage of usual, customary, and reasonable fees allowed, and timeframes for filing claims.

(1) Deductible amount—*[n]***N**etwork: per individual each calendar year, *[one thousand two hundred fifty dollars ($1,250)]* **one thousand six hundred fifty dollars ($1,650)**; family each calendar year, *[two thousand five hundred dollars ($2,500)]* **three thousand three hundred dollars ($3,300)**. Non-network: per individual each calendar year, *[two thousand five hundred dollars ($2,500)]* **four thousand dollars ($4,000)**; family each calendar year, *[five thousand dollars ($5,000)]* **eight thousand dollars ($8,000)**.

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(3) Out-of-pocket maximum—*[t]***T**he maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(C) Network out-of-pocket maximum for individual—*[two thousand five hundred dollars ($2,500)]* **Three thousand three hundred dollars ($3,300).**

(D) Network out-of-pocket maximum for family—*[five thousand dollars ($5,000)]* **Six thousand six hundred dollars ($6,600)**.

(4) Each subscriber will have access to all claim and payment information of the family unit.

*[(4)]***(5)** Any claim must be **initially** submitted within twelve (12) months *[of claim being incurred.]* **following the date of service.** The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(5)]***(6)** Usual, customary, and reasonable fee allowed—*[n]***N**on-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(6)]***(7)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(7)]***(8)** A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (8) of this *[regulation]* **rule**, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

*[(8)]***(9)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(10) Services received while out of the country may be covered if

the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2012] **2013**. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4), adding new sections (5) and (8), and renumbering as necessary.

PURPOSE: This amendment adds language regarding Influenza immunizations reimbursement amounts, which members will have access to claim and payment information within a family unit, and coverage of services received while out of the country; and revises language regarding the percentage of usual, customary, and reasonable fees allowed, and timeframe for filing claims.

(1) Deductible amount—*[n]***N**etwork: per individual each calendar year, six hundred dollars ($600); family each calendar year, one thousand two hundred dollars ($1,200). Non-network: per individual each calendar year, one thousand two hundred dollars ($1,200); family each calendar year, two thousand four hundred dollars ($2,400).

(B) The family deductible is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. *[Applicable charges received by one (1) family member may only meet the individual deductible amount.]* **Applicable charges received by one (1) family member may only contribute up to the individual deductible amount to the family deductible.**

(2) Coinsurance—*[c]***C**oinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(E) Preventive care—*[n]***N**etwork claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible. **Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.**

(4) Usual, customary, and reasonable fee allowed—Non-network medical claims are processed at the *[eighty-fifth]* **eightieth** percentile of usual, customary, and reasonable fees as determined by the vendor.

(5) Each subscriber will have access to all claim and payment information of the family unit.

*[(5)]***(6)** Any claim must be submitted **initially** within twelve (12) months *[of claim being incurred]* **following the date of service**. The plan reserves the right to deny claims not timely filed. **A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.**

*[(6)]***(7)** For a member who is **an** inpatient on the last calendar day of a plan year and remains **an** inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(8) Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities two thousand two hundred fourteen dollars ($2,214) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.056 PPO 600 Plan Benefit and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
380	**Subscribers enrolled in PPO 600 for CY 2014**	**$2,214**

III. WORKSHEET

Estimated cost is the projected increase in the subscriber's share of non-network paid claims for calendar year 2014 due to the MCHCP's share going from 85 percent to 80 percent of usual, customary and reasonable (UCR) charges for non-network claims. The estimated cost is calculated by multiplying total net paid for non-network PPO 600, 2012 claims by five percent.

IV. ASSUMPTIONS

- Calendar year 2014 membership will remain relatively stable
- Calendar year 2014 costs for non-network claims will remain relatively stable

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RESCISSION

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. This rule established the policy of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Rescinded: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

(1) Benefit Provisions Applicable to the PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension; or
7. Depression with one (1) other disease management condition.

(B) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension with one (1) other disease management condition; or
7. Depression with one (1) other disease management condition.

(C) A member identified as eligible for disease management through medical and prescription drug claims will receive an invitation to participate.

(4) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and

3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents).

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents).

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable.

H. Exercise Challenge Testing for exercise-induced bronchospasm

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: The following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy; and

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy.

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design,

implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only:

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g.,Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when:

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz: and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test sentences (HINT), and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multi-syllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500).

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

23. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status;

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. The professional fee for automated lab work is not a covered service;

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborn will be subject to coinsurance and deductible if mother is not covered under the plan;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions;

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the

use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom.

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis; and

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age of fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person.

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Rescinded and readopted: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions $2,776,922 in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $5,024,869 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$2,776,922**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for all public entity employees who enroll for coverage under this plan for calendar year 2014. Calculated by multiplying total public entity enrollment as of July 1, 2013 under each applicable rate tier by 50 percent of the total premium equivalent rates for each rate tier to determine the estimated cost based on the assumptions below.

IV. ASSUMPTIONS

- Calendar year 2014 membership in the public entity plans remains relatively stable;
- Calendar year 2014 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- The costs projected are for the public entity's share of the premium. Actual claim costs vary based upon utilization of services but the premium (both MCHCP's and subscriber's share of the premium) is projected to cover claim costs.

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
1.266 individuals enrolled in MCHCP public entity plans for CY 2014	**Individuals enrolled in MCHCP public entity plans for CY 2014**	**$5,024,869**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for all public entity employees who enroll for coverage under this plan for calendar year 2014. Calculated by multiplying total public entity enrollment as of July 1, 2013 under each applicable rate tier by the 50 percent of the total premium equivalent rates for each rate tier for Active Employee Only plus 100 percent of the additional premium for other levels of coverage to determine the estimated cost based on the assumptions below.

IV. ASSUMPTIONS

- Calendar year 2014 membership in the public entity plans remains relatively stable;
- Calendar year 2014 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium and that subscribers pay 100 percent of the additional premium for other levels of coverage;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- The costs projected are for the subscriber's share of the premium. Actual claim costs vary based upon utilization of services but the premium (both public entity's and subscriber's share of the premium) is projected to cover claim costs.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, *[PPO 2000 Plan,]* **and HDHP Limitations**. The Missouri Consolidated Health Care Plan is amending the title of the rule, section (1), and renumbering the rest of the sections and subsections as necessary.

PURPOSE: This amendment revises language regarding acts of war, alternative therapies, and custodial or domiciliary care; and adds language regarding charges exceeding vendor contracted rates or benefit limits, cosmetic procedures, bundled devices or supplies, telehealth, and therapies.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein **or in 22 CSR 10-3.057.**

*[(2)]***(A)** Abortion*[—other than situations where]* **unless** the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

*[(3)]***(B)** Acts of war **including**—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

*[(4)]***(C)** Alternative therapies—**that are outside conventional medicine** including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

*[(5)]***(D)** Assistive listening device.

*[(6)]***(E)** Assistant surgeon services—*[not covered]* unless determined to meet the clinical eligibility for coverage under the plan.

*[(7)]***(F)** Athletic *[trainer]* **training** services*[—services by a licensed athletic trainer not covered]*.

*[(8)]***(G)** Autopsy.

*[(9)]***(H)** Birthing center.

*[(10)]***(I)** Blood donor expenses*[—not covered]*.

*[(11)]***(J)** Blood pressure cuffs/monitors*[—not covered]*.

*[(12)]***(K)** Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

*[(13)]***(M)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(14)]***(N)** Childbirth classes.

*[(15)]***(O)** Comfort and convenience items.

(P) Cosmetic procedures.

*[(16)]***(Q)** Custodial or domiciliary care—*[includes]* **including** services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be *[provided]* **performed** by persons *[without the training of a health care provider]* **who are not providers**.

(R) Devices or supplies bundled as part of a service are not separately covered.

*[(17)]***(S)** Educational or psychological testing*[—not covered]* unless part of a treatment program for covered services.

*[(18)]***(T)** Examinations requested by a third party.

[(19)] Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.]

*[(20)]***(U)** Exercise equipment.

*[(21)]***(V)** Experimental *[services]* or investigational services*[—experimental or investigational services,]* procedures, supplies, or drugs as determined by the claims administrator *[are not covered]*.

*[(22)]***(W)** Eye services*[—health services]* and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(23)]***(X)** Services obtained at a government facility*[—not covered]* if care is provided without charge.

*[(24)]***(Y)** Gender reassignment*[—health]* services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

*[(25)]***(Z)** Health and athletic club membership—including costs of enrollment.

*[(26)]***(AA)** Home births.

*[(27)]***(BB)** Immunizations requested by third party *[or for travel]*.

*[(28)]***(CC)** Infertility treatment*[.]* **beyond the** *[Services are]* covered **services** to diagnose the condition.

*[(29)]***(DD)** Level of care, *[if]* greater than is needed for the treatment of the illness or injury.

*[(30)]***(EE)** Long-term care.

*[(31)]***(FF)** Maxillofacial surgery.

*[(32)]***(GG)** Medical care and supplies*[—not covered]* to the extent that they are payable under—

*[(A)]***1.** A plan or program operated by a national government or one (1) of its agencies; or

*[(B)]***2.** Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(33)]***(HH)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(34)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(35)]***(JJ)** Never events—*[twenty-eight (28)]* **never events are twenty-nine (29)** occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting*[. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability]*.

*[(36)]***(KK)** Nocturnal enuresis alarm.

*[(37)]***(LL)** Not medically-necessary services.

*[(38)]***(MM)** Orthoptics.

*[(39)]***(NN)** Other charges **as follows:**

1. *[—no coverage for charges]* **Charges** that would not **otherwise** be incurred if the subscriber was not covered **by the plan***[.]***;**

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted*[.]***;**

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan*[.]***; and**

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

*[(40)]***(OO)** Over-the-counter medications with or without a prescription including but not limited to analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(41)]***(PP)** Physical fitness.

*[(42)]***(QQ)** Private-duty nursing.

*[(43)]***(RR)** Self-inflicted injuries—not covered unless related to a mental diagnosis.

*[(44)]***(SS)** Sex therapy.

*[(45)]***(TT)** Surrogacy—pregnancy coverage is limited to plan member.

(UU) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(VV) Therapy. Physical, occupation, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic performance or for recreation;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs);

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance;

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(46)]***(WW)** Travel expenses*[—not covered except for transplants in a transplant network facility]*.

*[(47)]***(XX)** Workers' Compensation*[—charges for]* services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (4) and (6).

PURPOSE: This amendment revises the addresses and phone numbers to direct appeals and the guidelines under which the Board of Trustees and/or staff may grant an appeal.

(4) Appeal Process for Medical and Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-32.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
[8320 Ward Parkway] **9401 Indian Creek Parkway, Suite 1300**
[Kansas City, MO 64114] **Overland Park, KS 66210**

(b) Expedited appeals must be communicated by calling *[(816) 221-8400]* **(913) 202-5000** or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route *[0390]* **BL0390**
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

[Office of Consumer Information and
Oversight
Department of Health and Human Services
PO Box 791
Washington, DC 20044
or by fax to (202) 606-0036
or by email to disputedclaim@opm.gov]
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number *[(877) 549-8152]* **(888) 866-6205** with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal

adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines*[.]***:**

[(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's birth date.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan.

(I) Loss of coverage notice—MCHCP may approve a late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(K) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(L) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan.]

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn retroactively to the date of birth if the initial request is made in writing to the board of trustees within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal for the request to be considered;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected during the annual open enrollment period if the request is made within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. The subscriber must include payment in full for all past and current premiums due for reinstatement;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by a cafeteria plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is timely from date of late notice;

(H) MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period;

(I) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan;

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline; and

(K) MCHCP may approve an appeal to change a subscriber's

medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (8), adding a new section (9), and renumbering as necessary.

PURPOSE: This amendment revises language regarding PPO 600 and PPO 1000 plan member copayments, home delivery days supply, maintenance prescription fill selection, prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine, and contraception covered at one hundred percent (100%); HDHP with HSA plan coinsurance, home delivery days supply, and maintenance prescription fill selection, prescription and over-the-counter drugs, Vitamin D, influenza and shingles vaccine, and contraception covered at one hundred percent (100%); and formulary updates, Disease Management eligibility for reduced copayments and quantity level limits. This amendment adds language regarding compound drug copayments and out-of-pocket maximum amounts for members enrolled in the PPO 600 and PPO 1000 plans.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) *[PPO 600, PPO 1000, and PPO 2000]* **PPO 600 and PPO 1000** Prescription Drug Coverage.

1. Network:

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply** for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply** for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply**; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply** for a drug not on the formulary;

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program *[or through a retail pharmacy that has agreed to fill maintenance prescriptions at a comparable price to the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits]*.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply, and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).]*

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

[(II) Select home delivery—]

*[(a)]***(d)** A member must choose how *[s/he will fill his/her]* maintenance prescription(s)*[. A member must notify]* **will be filled by notifying** the pharmacy benefit manager **(PBM)** of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

*[(b)]***(e)** If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the *[pharmacy benefit manager]* **PBM** of his/her decision, the first two (2) maintenance prescription orders *[can]* **may** be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the *[pharmacy benefit manager]* **PBM** of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. *[Once the pharmacy benefit manager has been notified of the member's decision to purchase his/her maintenance prescription(s) through a retail pharmacy, the retail election remains in place for one (1) year. After one (1) year, the member will be required to make a choice between home delivery and retail pharmacy for maintenance prescriptions]* **If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision**; and

*[(c)]***(f)** Once a member makes his/her delivery *[election]* **decision**, the member can modify *[his/her election]* **the decision** by contacting the *[pharmacy benefit manager]* **PBM**; and

*[(III)]***(II)** Specialty drugs **are** covered only through *[network]* **the specialty** home delivery **network** for up to **a** *[thirty (30) days]* **thirty-one- (31-) day supply**. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayments: Eight dollars ($8) for a generic drug on the formulary list.

(b) Brand copayments: Thirty-five dollars ($35) for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred*[-]*dollars ($100) for a drug not on the formulary; and

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount**;**

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix;

*[F.]***G.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[G.]***H.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

*[H.]***I.** *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%), as prescribed by a physician and included on the formulary through the pharmacy benefit manager.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less the applicable copayment.

A. Generic copayment: Eight dollars ($8) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

3. Out-of-pocket maximum. The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

A. Network and non-network out-of-pocket maximums are not separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—six thousand two hundred fifty dollars ($6,250).

D. Family—twelve thousand dollars ($12,000)

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network:

A. Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible for a generic drug on the formulary; *[formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; *[formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);]*

C. Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. *[Some medications may not apply for the program because they require prior authorization or quantity level limits.]*

(a) Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible for a generic drug on the formulary*[; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)]*.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary*[; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)]*.

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs covered only through network home delivery for up to thirty-**one-** *[(30)]* **(31-)** days.

(a) Generic: *[Twenty]* **Ten** percent *[(20%)]* **(10%)** coinsurance after deductible **has been met** for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible **has been met** for a brand drug on the formulary.

(c) Non-formulary: *[Thirty]* **Forty** percent *[(30%)]* **(40%)** coinsurance after deductible **has been met** for a drug not on the formulary; and

E. *[Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.]* **Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):**

(I) Prescribed Vitamin D for all ages;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the *[pharmacy benefit manager]* **PBM**. The *[pharmacy benefit manager]* **PBM** will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible **has been met** for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first-step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the physician may request a prior authorization from the *[pharmacy benefit manager]* **PBM**. If the prior authorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(3) Disease Management **(DM)** Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the *[Disease Management]* **DM** Program and enrolled in the PPO 600 Plan*[,]* PPO 1000 Plan*[, or PPO 2000 Plan]* are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty-**one-** *[(30-)]* **(31-)** day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the *[Disease Management]* **DM** Program when s/he is enrolled in a *[Disease Management]* **DM** Program through the medical plan vendor and one (1) of the following*[—]***:**

1. Is working one-on-one with a nurse; or

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a nurse until **the medical plan vendor determines** the condition *[is]* **can be** managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a **DM** nurse.

(C) A member is no longer eligible for reduced non-formulary prescription copayment when the medical plan vendor determines s/he is no longer actively participating in the DM program.

(4) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. *[Members]* **A member** may request **a** claim form*[s]* from the plan or the *[pharmacy benefit manager]* **PBM**. In order to file a claim, **the** member*[s]* must—

(C) *[Members]* **A member** must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted amount as determined by the *[pharmacy benefit manager]* **PBM**, less any applicable copayment, deductible, or coinsurance. *[Members are]* **A member is** responsible for any charge over the network discounted price and the applicable copayment.

(5) Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; *[or]*

(C) A drug is determined to have a safety issue **by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer covered under the pharmacy benefit**.

(8) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the *[Food and Drug Administration and]* **FDA or credible scientific evidence published in peer-reviewed** medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

(10) Affordable Care Act (ACA) required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expires June 29, 2014. Amended: Filed Oct. 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety- (90-) day period during which an agency shall file its Order of Rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the Proposed Rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 18—Safety Standards

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.310 and 394.160, RSMo 2000, the commission amends a rule as follows:

4 CSR 240-18.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1377–1381). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended October 3, 2013, and the commission held a public hearing on the proposed amendment on October 4, 2013. The commission received a timely written comment from the staff of the Missouri Public Service Commission. The commission's staff elaborated upon its comment at the hearing.

COMMENT: The commission's staff offered a written comment pointing out that the proposed amendment makes reference to an Errata issued on February 6, 2012 by the Institute of Electrical and Electronics Engineers, Inc. Subsequently, that Institute issued an updated Errata on April 29, 2013. Staff advises the commission to modify the amendment to refer to the more recent April 29, 2013 Errata instead of the February 6, 2012 Errata.
RESPONSE AND EXPLANATION OF CHANGE: The commission has modified the amendment as proposed by staff.

4 CSR 240-18.010 Safety Standards for Electrical Corporations, Telecommunications Companies and Rural Electric Cooperatives

(1) The minimum safety standards relating to the operation of electrical corporations, telecommunications companies, and rural electric cooperatives are Parts 1, 2, and 3 and Sections 1, 2, and 9 of the *National Electrical Safety Code* (NESC); 2012 Edition as approved by the American National Standards Institute on August 1, 2011, as modified by Errata thereto issued on April 29, 2013, and published by the Institute of Electrical and Electronics Engineers, Inc., 3 Park Avenue, New York, NY 10016-5997. The NESC is composed of four (4) different parts and four (4) sections, each of which pertain to different aspects of the electric and telecommunications industries. Part 1 specifies rules for the installation and maintenance of equipment normally found in electric generating plants and substations. Part 2 pertains to safety rules for overhead electric and communication lines. Part 3 contains safety rules for underground electric and communication lines. Section 1 is an introduction to the NESC, Section 2 defines special terms, and Section 9 requires certain grounding methods for electric and communications facilities. The full text of this material is available at the Energy Department of the Public Service Commission, Suite 700, 200 Madison, Jefferson City, Missouri. This rule does not incorporate any subsequent amendments or additions.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 50—Water Utilities

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.310 and 393.140, RSMo 2000, and section 386.266, RSMo Supp. 2013, the commission adopts a rule as follows:

4 CSR 240-50.050 Environmental Cost Adjustment Mechanism **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 16, 2013 (38 MoReg 1477–1480). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended October 16, 2013, and the commission held a public hearing on the proposed rule on October 24, 2013. The commission received a timely written comment from Missouri American Water Company. The Office of the Public Counsel, Missouri American Water Company, and the commission's staff appeared at the hearing.

COMMENT #1: Missouri American Water Company's written comment indicates the company supports the rule as proposed by the commission. Frank L. Kartmann, President of Missouri American Water Company, appeared at the hearing and again offered Missouri American's support for the rule as proposed.
RESPONSE: The commission thanks Missouri American Water Company for its comment.

COMMENT #2: Public Counsel appeared at the hearing and indicated it has no comments either in support or in opposition to the proposed rule.
RESPONSE: The commission thanks Public Counsel for its comment.

COMMENT #3: The commission's staff appeared at the hearing and indicated its willingness to answer any questions about the proposed rule. Staff had no other comments either in support or in opposition to the proposed rule.
RESPONSE: The commission thanks its staff for its willingness to answer questions.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 26—Petroleum and Hazardous Substance Storage Tanks
Chapter 2—Underground Storage Tanks—Technical Regulations

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission (commission) under sections 319.109 and 319.137, RSMo Supp. 2013, the commission hereby amends a rule as follows:

10 CSR 26-2.062 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2013 (38 MoReg 1160–1161). Those sections with changes are reprinted here. Additionally, the incorporated by reference material has been changed as a result of comments. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on August 15, 2013, and the public comment period ended on August 22, 2013. The Missouri Department of Natural Resources' Hazardous Waste Program received thirty-three (33) comments regarding the guidance document proposed for incorporation by reference at subsection (3)(A) of the amended rule. The comments came from five (5) sources, as follows: Brian Porter, Terracon; Carol Eighmey, Petroleum Storage Tank Insurance Fund; Donnie Greenwalt, Wallis Companies; Mark Jordan, Wallis Companies; and Ron Leone, Missouri Petroleum Marketers and Convenience Store Association. The Hazardous Waste Program did not receive any comments regarding the rule language itself. However, department staff have determined that changes made to the January 1, 2013, version of the *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks* guidance document as a result of comments received during the public comment period necessitate that the date of the guidance be changed in the rule in order to differentiate the final guidance from the January 1, 2013, version. The department proposes to revise subsection (3)(A) of 10 CSR 26-2.062 to reflect a guidance publication date of October 17, 2013.

COMMENT #1: Brian Porter stated the following: "One of the main reasons for revising the tanks Missouri Risk-Based Corrective Action (MRBCA) guidance was a desire to update its risk-based levels with the most current toxicological data and scientific methodology utilized by the Environmental Protection Agency (EPA) and other federal and state agencies. The result would be consistent target levels for Missouri's tanks and Brownfield Voluntary Cleanup Program (B/VCP) that are in line with the most current information used throughout the country.

The proposed updates to the tanks guidance include revisions to the target levels so that they are consistent with the departmental [MRBCA] target levels currently in use. However, we understand that a forthcoming update to the departmental guidance will further update its target levels. If the updates to the tanks guidance occur as currently scheduled, Missouri's guidance documents will contain consistent target levels for only a very brief period (a matter of months at most). Thereafter, the guidance documents will conflict with each other once again.

Acknowledging that the tanks guidance process has been delayed several times already, it seems prudent to delay it one more time so that both it and the departmental guidance can benefit from the latest toxicological and scientific methodology."
RESPONSE: Mr. Porter's understanding regarding the department's updating of the Departmental Risk-Based Target Levels (RBTLs) is correct; the department has begun that effort and expects draft updated RBTLs to be developed by the end of 2013. Sometime thereafter, the draft RBTLs will be the subject of a sixty- (60-) day public comment period. Mr. Porter is also correct in his statement that the department's updating of the departmental RBTLs will result in those RBTLs differing from the RBTLs in the Tanks Risk-Based Corrective Action (RBCA) guidance.

The RBTLs in the updated Tanks RBCA guidance are based on methodology and toxicity and other inputs that were current in 2009. While the department is aware that the methodology and inputs have changed since that time, and despite the department's preference that the RBTLs in both RBCA documents be the same, the updated Tanks RBCA guidance associated with this rulemaking is the result of protracted negotiations between the department and tanks stakeholders during 2012 and early 2013. Those negotiations resulted in all parties agreeing to move ahead with the 2009 RBTLs. As the department's efforts to revise the departmental RBTLs have only recently begun, and we cannot ensure that the update will be completed on the anticipated schedule, the department will move ahead with the 2009 RBTLs (that are consistent with the current departmental RBTLs) that are found in the Tanks RBCA guidance associated with this rulemaking.

COMMENT #2: Carol Eighmey stated that much duplicative, inconsistent, or erroneous language in the previous version of the Tanks RBCA guidance has been eliminated or corrected with this update of the guidance, and that this alone makes this rulemaking a worthwhile endeavor.
RESPONSE: The department appreciates Ms. Eighmey's comment in support of this rulemaking.

COMMENT #3: Ms. Eighmey pointed out that the department's proposed rulemaking eliminates the requirement to use standardized forms in various reports, and that this is "a huge improvement." She stated that the requirement to use these standardized forms is now clearly obsolete and that some of the forms are no longer even accurate. Ms. Eighmey indicated that the PSTIF looks forward to the elimination of this requirement.
RESPONSE: The department appreciates Ms. Eighmey's comment in support of this change.

COMMENT #4: Ms. Eighmey stated "the proposed rulemaking *does* impose some new requirements and changes some of the numerical cleanup standards. We have reviewed the proposed changes and – while we're not fans of all of them, and some of them will increase costs – we nevertheless believe they are reasonable and can be implemented without *unduly* increasing costs."
RESPONSE: The department appreciates Ms. Eighmey's understanding and support of the new requirements.

COMMENT #5: Ms. Eighmey stated that what has been accomplished with this rulemaking and guidance update – "while it undoubtedly falls short of perfect – is a *significant and substantial* step forward, and one that is long overdue."
RESPONSE: The department agrees with Ms. Eighmey's comment

and appreciates her support of the rulemaking.

COMMENT #6: Ms. Eighmey stated that the first paragraph in Subsection 1.1 of the updated Tanks RBCA guidance accurately refers to the 2004 RBCA guidance document as "draft guidance." She suggests that the first sentence in the second paragraph of the subsection be revised as follows: "In 2005, the process provided for by the **draft** guidance was modified…"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence of Subsection 1.1 has been changed to read: "In 2005, the process provided for by the draft guidance was modified by the addition of six (6) supplemental guidance documents."

COMMENT #7: Ms. Eighmey stated that the second sentence in Subsection 2.1 of the updated guidance refers to Section 1.3 of the Guidance Document, which will no longer exist. She suggests deleting the phrase, "…as discussed at Section 1.3 of this document…"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of Subsection 2.1 has been revised to read: "The MRBCA process begins when a petroleum release is suspected or discovered and includes all subsequent activities (except those conducted under 260.500 through 260.550 RSMo and the regulations promulgated thereunder) until MDNR issues a 'No Further Action' (NFA) letter for the release."

COMMENT #8: Ms. Eighmey suggests renaming Subsection 2.2.1 of the updated guidance "**Release** Discovery" instead of "Site Discovery," to be consistent with other language in the guidance.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. Subsection 2.2.1 of the updated guidance has been renamed "Release Discovery."

In addition, the department has changed the first sentence of Subsection 2.2.1 of the updated guidance to refer to the discovery of a release at an underground storage tank (UST)/above ground storage tank (AST) site rather than the discovery of "contamination." In addition, "site" also appeared in the second and third sentences of Subsection 2.2.1 as well as the first sentence of the second paragraph of the subsection. Where appropriate, the department has changed the use of "site" in the subsection to "release," as follows:

"The MRBCA process begins with the discovery of a release at a UST/AST site. A release might be discovered and reported to the MDNR under a variety of circumstances including, but not limited to, (i) system closure, (ii) a site check investigation resulting in confirmation of a release, and (iii) identification of an imminent hazard (e.g., vapors in sewers or buildings, etc.). Releases might also be identified during investigations conducted as a part of real estate transactions, investigations conducted in anticipation of land development, and the occurrence of accidents and spills.

The release discovery process should generally result in the identification of affected media at a site and generate analytical data. This initial data should, ideally, represent the point or points of release, the chemicals of concern (COCs), and the maximum concentrations of the COCs."

COMMENT #9: Ms. Eighmey suggests revising the fourth sentence of Subsection 2.4 of the updated guidance as follows, "Such communication must occur throughout the MRBCA process, from **release** discovery to issuance…," to be consistent with other language in the guidance.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The fourth sentence of Subsection 2.4 has been revised to read: "Such communication must occur throughout the MRBCA process, from release discovery to issuance of a NFA letter, so that interested parties can determine if decisions made and activities undertaken during the MRBCA process at a site were sufficient to adequately protect human health and the environment."

COMMENT #10: Ms. Eighmey suggests revising the first sentence of the second paragraph of Subsection 3.1 of the updated guidance as follows: "…may ultimately lead to *[site]* discovery **of a release**."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence of the second paragraph of Subsection 3.1 has been revised to read: "A number of different events may trigger site-specific activities that may ultimately lead to release discovery."

COMMENT #11: Ms. Eighmey stated that, since an explicit list of required photographs is being added to the guidance, the previous, less-precise sentence toward the end of Subsection 4.4.1 that says, "During the tank closure process, sufficient color photographs shall be collected to document the condition of tanks, excavation, pads, etc., and submitted with the closure report" should be deleted.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts the comment. The second-to-last sentence in Subsection 4.4.1 has been deleted from the updated guidance.

COMMENT #12: Ms. Eighmey suggests revising Subsection 4.5.8 of the updated guidance to more accurately describe current practices, as follows: "If treatment will be via on-site landfarming, **approval must be obtained from MDNR's Tanks Section as part of the Corrective Action Plan (CAP) for the petroleum release. Off-site landfarms require a permit issued by MDNR's Water Protection Program (WPP); f**or information *[concerning landfarm permits,]* contact MDNR's WPP at …"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of Subsection 4.5.8 has been revised to read: "If treatment will be via on-site landfarming, approval must be obtained from MDNR's Tanks Section as part of the CAP for the petroleum release. Off-site landfarms require a permit issued by MDNR's WPP; for information, contact MDNR's WPP at (573) 751-1300."

COMMENT #13: Ms. Eighmey suggests revising the last item in the third bulleted list of Subsection 5.1 to be consistent with change to terminology made throughout the document, as follows: "Information about corrective action measures *[or risk management activities]* that have been conducted and are planned."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The last item in the third bulleted list has been revised to read: "Information about corrective action measures that have been conducted and are planned."

COMMENT #14: Also in Subsection 5.1, Ms. Eighmey suggests revising the first sentence of the paragraph following the third bulleted list as follows: "…beyond that discussed herein might be required to develop a **Corrective Action Plan** or to complete a Tier 3…"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence in the paragraph following the third bulleted list in Subsection 5.1 has been revised to read: "Note: Additional data beyond that discussed herein might be required to develop a Corrective Action Plan (CAP) or to complete a Tier 3 risk assessment."

COMMENT #15: Ms. Eighmey states that the first paragraph of Subsection 5.2 of the updated guidance appears to have been written in 2004 to help owners and their consultants understand how to transition to the new MRBCA Guidance. She indicates that the paragraph is largely obsolete today and – as a summary of the RBCA process – discusses in a general way the tasks that are more specifically presented throughout the document. Ms. Eighmey suggests deleting the entire paragraph.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment in part. The department believes some of the language in the first paragraph of Subsection 5.2 is valuable and therefore should be retained. The paragraph has been

revised to read as follows: "As part of the MRBCA evaluation, the person undertaking the evaluation must carefully review all existing data and identify any data gaps. Only after all the necessary data have been collected and full site characterization is complete should the person undertaking the evaluation proceed with the development of target levels."

COMMENT #16: Ms. Eighmey points out that the second paragraph of Subsection 5.4.5 of the updated guidance references MEGA, a compilation of data that is now obsolete. She suggests revising the paragraph as follows: "Two (2) valuable sources of regional hydrogeology and aquifer characteristic information are the Well Information System, which contains all records of known wells in Missouri and is available at http://dnr.mo.gov/mowells/publicLanding.do, and "CARES" maps, available at http://ims.missouri.edu/moims/step1.aoi/countylist.asp."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second paragraph of Subsection 5.4.5 has been revised to read: "Two (2) valuable sources of regional hydrogeology and aquifer characteristic information are the Well Information System, which contains all records of known wells in Missouri and is available at http://dnr.mo.gov/mowells/publicLanding.do, and Center for Applied Research and Environmental Systems or "CARES" maps, available at http://ims.missouri.edu/moims/step1.aoi/countylist.asp."

COMMENT #17: Ms. Eighmey states that the last paragraph of the text added to Subsection 5.6.4 as part of the guidance update advises the reader to "refer to Subsection 5.8 for developing a sampling plan for VWC." She indicates that, though Subsection 5.8 contains helpful information for designing one's sampling plan, it is not specific to volumetric water content (VWC). Ms. Eighmey suggests deleting the words "for VWC" from the text in Subsection 5.6.4.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The last paragraph of Subsection 5.6.4 has been revised to read: "Refer to Subsection 5.8 for developing a sampling plan. Because VWC varies over time most significantly in surficial soil, VWC data should not be collected from surficial soil (i.e., 0 – 3') except when the foundation of an existing building is less than three feet (3') deep."

COMMENT #18: Ms. Eighmey states that Subsection 5.9.1 conflicts with information contained in Subsection 6.3.3 regarding point of demonstration (POD) and point of exposure (POE). She suggests that the subsection be revised accordingly.
RESPONSE: The department does not agree that the two (2) subsections are in conflict, because Subsection 5.9.1 pertains to delineation of contaminants in groundwater whereas Subsection 6.3.3 pertains to the evaluation of the groundwater use pathway. Therefore, no change is proposed.

COMMENT #19: Ms. Eighmey comments that the department accepts Method 3511 for total petroleum hydrocarbons-diesel range organics (TPH-DRO), as long as the lab meets the same detection limits and quality assurance/quality control (QA/QC) requirements as for other methods. She suggests that Method 3511 be added to Table 5-1 as an option for TPH-DRO.
RESPONSE: The department does not accept Ms. Eighmey's comment. Method 3511 is a micro-extraction procedure; it is not an analysis procedure to quantify concentrations of COCs. The information in Table 5-1 includes analysis procedures. While the Tanks Section has approved the use of Method 3511, the guidance is not structured to include such extraction methods, but rather only analytical methods. Therefore, the department has not made the suggested addition.

COMMENT #20: Ms. Eighmey suggests that the following sentence be inserted into the updated guidance at the end of Subsection 6.1.2.1: "Because petroleum equipment companies are subject to other regulatory requirements regarding worker exposure, it is not necessary to evaluate dermal contact risk associated with soil or groundwater exposures in the areas of the property where tanks/piping are located."
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the essence of Ms. Eighmey's comment, but not all of the suggested language. The subject of the comment was also the subject of a July 3, 2013, memorandum from Aaron Schmidt of the department to which Ms. Eighmey referred in her oral comments to the Hazardous Waste Management Commission at the August 15, 2013, public hearing regarding the subject rule amendments and updated guidance. In that memorandum, the scope of the exception described in the memo and Ms. Eighmey's comment is limited to the tank pit as defined in the memorandum. The department intends for the language to be added at the end of Subsection 6.1.2.1 to reflect the scope defined in the memorandum. Therefore, in response to this comment, the department has inserted the following language at the end of Subsection 6.1.2.1: "Because petroleum equipment companies are subject to other regulatory requirements regarding worker exposure, it is not necessary to evaluate the soil ingestion, inhalation, and dermal contact exposure pathway nor the dermal contact with groundwater exposure pathway for the construction worker receptor in the area in which an active underground storage tank (i.e., the tank pit) is located."

COMMENT #21: Ms. Eighmey suggests inserting the following sentence at the end of Subsection 6.1.3.1: "At an active tank facility, the exposure model can assume no building will be constructed over the tank pit or where the dispensers are located."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment in part. The subject of the comment was also the subject of a July 3, 2013, memorandum from Aaron Schmidt of the department to which Ms. Eighmey referred in her oral comments to the Hazardous Waste Management Commission at the August 15, 2013, public hearing regarding the subject rule amendments and updated guidance. With respect to the exposure model limitation, the memorandum states "When evaluating the indoor inhalation of vapors exposure pathways for soil and groundwater for a future residential or non-residential land use scenario, the tank pit need not be included in the evaluation. All areas outside of the tank pit shall be included in the evaluation." The department has not incorporated Ms. Eighmey's suggested language "where the dispensers are located" into the subsection because the memorandum applies only to the tank pit. The department intends for the language added at the end of Subsection 6.1.3.1 to be consistent with Mr. Schmidt's memorandum. Therefore, the department has added the following language to the end of Subsection 6.1.3.1: "The exposure model for an active tank facility may assume that no building will be constructed over the tank pit."

COMMENT #22: So that the text will match the terminology used in Table 7-4, Ms. Eighmey suggests that the third paragraph of Subsection 7.5 of the updated guidance be revised as follows: "Depending on this distance **and the depth** to groundwater…,"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of the third paragraph of Subsection 7.5 has been revised to read: "Depending on this distance and the depth to groundwater, as discussed above, soil concentrations protective of groundwater will be selected from Tables 7-4(a), 7-4(b), or 7-4(c)."

COMMENT #23: Ms. Eighmey states that the text added (during updating of the guidance) just before Subsection 9.1 references "light non-aqueous phase liquid" and "LNAPL" in several places. She asks whether this paragraph should use the term "free product" instead of "light non-aqueous phase liquid" or "LNAPL."
RESPONSE: The department feels the use of "LNAPL" rather than "free product" is appropriate in the paragraphs just before Subsection

9.1 because the analytical limitations that necessitate the requirements stated in the paragraphs pertain equally to both mobile (i.e., "free product") and immobile LNAPL. In the experience of the department, analytical laboratories frequently refrain from analyzing grossly contaminated samples (i.e., samples with mobile and/or immobile LNAPL) because such samples can result in equipment being out of use for extended periods due to the need to thoroughly clean the equipment and due to the difficulty in accurately quantifying all chemicals of concern in such samples. The latter is due to the need to dilute such samples such that the detection limits for some of the COCs are elevated to a degree that the concentrations of the chemicals cannot be meaningfully quantified. Therefore, the department has not made any change to the paragraphs immediately preceding Subsection 9.1.

COMMENT #24: Ms. Eighmey states that the second bulleted list in Subsection 10.1 contains two (2) references to "LNAPL" in two (2) places. She suggests deleting the first reference and changing the second to "free product."
RESPONSE AND EXPLANATION OF CHANGE: The department does not agree with Ms. Eighmey's suggestions. The sentence preceding the second bulleted list in Subsection 10.1 reads: "The overall objective of a [Corrective Action Plan] is to ensure that:" The third bullet thereafter correctly explains the conditions related to LNAPL and free product that the Corrective Action Plan is to address or prevent. However, upon review, the department finds the language in the third bullet of the second bulleted list in Subsection 10.1 is unclear with regard to whether the conditions stated there pertain to LNAPL, free product, or both.

To ensure the requirements of Subsection 10.1 are clear, the department has revised the language of the third bullet in the second bulleted list in the subsection to read as follows: "Mobile or immobile light non-aqueous phase liquids (LNAPL; mobile LNAPL is referred to as "free product") are not present in the soil or groundwater in volumes that will result in any of the following conditions: (i) an expanding free product plume in soil or groundwater, (ii) an expanding dissolved plume, (iii) unacceptable risk to human health or the environment, and (iv) explosive or fire hazard."

These changes are based on the department's contention that an expanding dissolved phase contaminant plume and unacceptable risk to human health or the environment could be caused by either LNAPL or free product. We contend that the same is arguably true with respect to the creation of an explosion or fire hazard as well. However, we acknowledge that only free product is subject to migration and therefore have replaced "LNAPL" at (i) with "free product."

COMMENT #25: Ms. Eighmey comments that the numbering of the footnotes in Appendix C of the updated guidance may need to be corrected.
RESPONSE: The department thanks Ms. Eighmey for the comment and has ensured that the numbering of the footnotes is correct.

COMMENT #26: Mr. Greenwalt stated that, overall, he has no major concerns with what the new rules or Tanks RBCA guidance document contain and that he believes the department, the Petroleum Storage Tank Insurance Fund, and the Missouri Petroleum Marketers and Convenience Store Association put forth a great effort to collaborate and compromise on a streamlined document that will hopefully make the RBCA process less cumbersome and help facilitate site closures. Mr. Greenwalt further stated that, while this latest version of the RBCA guidance might not be perfect, it is clearly an improvement over the previous version of the guidance based on the consolidation and elimination of redundancy and useless requirements.
RESPONSE: The department appreciates Mr. Greenwalt's support of this rulemaking effort.

COMMENT #27: Mr. Greenwalt stated that he has a few comments on the requirements contained in Subsection 6.1.1.2 (Determination of Reasonably Anticipated Future Land Use (RAFU)) of the updated RBCA guidance and, more importantly, the administration of this particular section by the department's project managers. He goes on to say that he is not strongly opposed to the addition of "interviews with property owners" to the list of factors in Subsection 6.1.1.2 that may be used to determine the RAFU of a property, but rather that he disagrees with the disproportionate amount of weight given to this factor by the department's project managers.
RESPONSE: Most of the comments submitted by Mr. Greenwalt pertain to how the department implements those parts of the guidance pertaining to RAFU decisions – in particular how information from property owners is gathered and managed – rather than to the language of the amended rules or the updated guidance themselves. Rulemaking public comment periods, including the comment period for this rulemaking, provide the public with an opportunity to submit comments in support, comments in opposition, or comments suggesting edits to the specific proposed rules and any material to be incorporated by reference. Mr. Greenwalt's comments pertaining to the department's implementation of the guidance to be incorporated by reference are therefore outside of the scope of the rulemaking and the department has not responded to those in this order of rulemaking. In addition, in his comments, Mr. Greenwalt does not suggest any changes to the rules or the updated guidance document.

COMMENT #28: Mr. Greenwalt states that, although the updated Tanks RBCA guidance document has not been accepted by the Hazardous Waste Commission, some of the department's project managers have, for some time, been requiring (not simply requesting) that information regarding future property use be obtained from current property owners.
RESPONSE: The statement "interviews with property owners" in Subsection 6.1.1.2 of the updated Tanks RBCA guidance is not new language; the same language appeared in Subsection 5.5.2 of the 2004 version of the Tanks RBCA guidance. Along with other information in Subsection 5.5.2 of the 2004 guidance, the statement "interviews with property owners" was moved to Subsection 6.1.1.2 of the updated guidance in order to consolidate in Section 6 information related to RAFU.

COMMENT #29: Mr. Jordan commended the department for its efforts to develop a broad consensus on complex and difficult topics.
RESPONSE: The department thanks Mr. Jordan for his comment.

COMMENT #30: Mr. Jordan stated that his sole comment pertains to Subsection 6.1.1.2 of the updated Tanks RBCA guidance. He suggested that "interviews with current property owners" be deleted from the subsection and replaced by "information obtained from current property owners by the consultant or the responsible party."
RESPONSE: The department does not agree with Mr. Jordan's suggestion because the suggested language would limit the department's ability to obtain information from current property owners. The department believes it is both reasonable and appropriate for its project managers to gather information from property owners, whether in lieu of a consultant or responsible party or in order to verify information submitted by a consultant or responsible party. The department's role of overseeing RBCA evaluations includes verifying information submitted by consultants by contacting or finding other, additional sources of information.

In addition, the statement "interviews with property owners" in Subsection 6.1.1.2 of the updated Tanks RBCA guidance is not new language; the same language appeared in Subsection 5.5.2 of the 2004 version of the Tanks RBCA guidance. Along with other information in Subsection 5.5.2 of the 2004 guidance, the statement "interviews with property owners" was moved to Subsection 6.1.1.2 of the updated guidance in order to consolidate in Section 6 information related to RAFU.

COMMENT #31: Mr. Leone stated that the Missouri Petroleum Marketers & Convenience Store Association (MPCA) "fully supports and incorporates herein by reference both the written comments being submitted by Mark Jordan & Donnie Greenwalt with Wallis Companies and the 8/15/13 public testimony presented by the Petroleum Storage Tank Insurance Fund (PSTIF)."
RESPONSE: The department's responses to the comments submitted by Mr. Greenwalt, Mr. Jordan, and Ms. Eighmey are contained within this order of rulemaking.

COMMENT #32: Mr. Leone stated that "MPCA believes the proposed RBCA rule changes are for the most part necessary, reasonable [and] measured, and we ask that you seriously consider the comments and suggestions provided by both PSTIF and Wallis Companies."
RESPONSE: The department thanks Mr. Leone for the comment. The department has given serious consideration to all of the comments submitted and has provided a response to each in this order of rulemaking.

COMMENT #33: Mr. Leone thanked department staff for their hard work to develop the amendments and update the Tanks RBCA guidance.
RESPONSE: The department thanks Mr. Leone for his comments recognizing the work of department staff in relation to this rulemaking.

10 CSR 26-2.062 Assessing the Site at Closure or Change in Service

(3) Owners and operators shall follow a written procedure.

(A) To comply with this rule, owners and operators may use the *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks* guidance document, October 17, 2013, which is hereby incorporated by reference without any subsequent amendments or additions, and is published by the Department of Natural Resources, PO Box 176, Jefferson City, MO 65102-0176.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 26—Petroleum and Hazardous Substance Storage Tanks
Chapter 2—Underground Storage Tanks—Technical Regulations

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission (commission) under sections 319.109 and 319.137, RSMo Supp. 2013, the commission hereby amends a rule as follows:

10 CSR 26-2.078 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2013 (38 MoReg 1161–1162). Those sections with changes are reprinted here. Additionally, the incorporated by reference material has been changed as a result of comments. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on August 15, 2013, and the public comment period ended on August 22, 2013. The Missouri Department of Natural Resources' Hazardous Waste Program received thirty-three (33) comments regarding the guidance document proposed for incorporation by reference at paragraph (3)(C)1. of the amended rule. The comments came from five (5) sources, as follows: Brian Porter, Terracon; Carol Eighmey, Petroleum Storage Tank Insurance Fund; Donnie Greenwalt, Wallis Companies; Mark Jordan, Wallis Companies; and Ron Leone, Missouri Petroleum Marketers and Convenience Store Association. The Hazardous Waste Program did not receive any comments regarding the rule language itself. However, department staff have determined that changes made to the January 1, 2013, version of the *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks* guidance document as a result of comments received during the public comment period necessitate that the date of the guidance be changed in the rule in order to differentiate the final guidance from the January 1, 2013, version. The department proposes to revise paragraph (3)(C)1. of 10 CSR 26-2.078 to reflect a guidance publication date of October 17, 2013.

COMMENT #1: Brian Porter stated the following: "One of the main reasons for revising the tanks Missouri Risk-Based Corrective Action (MRBCA) guidance was a desire to update its risk-based levels with the most current toxicological data and scientific methodology utilized by the Environmental Protection Agency (EPA) and other federal and state agencies. The result would be consistent target levels for Missouri's tanks and Brownfield Voluntary Cleanup Program (B/VCP) that are in line with the most current information used throughout the country.

The proposed updates to the tanks guidance include revisions to the target levels so that they are consistent with the departmental [MRBCA] target levels currently in use. However, we understand that a forthcoming update to the departmental guidance will further update its target levels. If the updates to the tanks guidance occur as currently scheduled, Missouri's guidance documents will contain consistent target levels for only a very brief period (a matter of months at most). Thereafter, the guidance documents will conflict with each other once again.

Acknowledging that the tanks guidance process has been delayed several times already, it seems prudent to delay it one more time so that both it and the departmental guidance can benefit from the latest toxicological and scientific methodology."
RESPONSE: Mr. Porter's understanding regarding the department's updating of the Departmental Risk-Based Target Levels (RBTLs) is correct; the department has begun that effort and expects draft updated RBTLs to be developed by the end of 2013. Sometime thereafter, the draft RBTLs will be the subject of a sixty- (60-) day public comment period. Mr. Porter is also correct in his statement that the department's updating of the departmental RBTLs will result in those RBTLs differing from the RBTLs in the Tanks Risk-Based Corrective Action (RBCA) guidance.

The RBTLs in the updated Tanks RBCA guidance are based on methodology and toxicity and other inputs that were current in 2009. While the department is aware that the methodology and inputs have changed since that time, and despite the department's preference that the RBTLs in both RBCA documents be the same, the updated Tanks RBCA guidance associated with this rulemaking is the result of protracted negotiations between the department and tanks stakeholders during 2012 and early 2013. Those negotiations resulted in all parties agreeing to move ahead with the 2009 RBTLs. As the department's efforts to revise the departmental RBTLs have only recently begun, and we cannot ensure that the update will be completed on the anticipated schedule, the department will move ahead with the 2009 RBTLs (that are consistent with the current departmental RBTLs) that are found in the Tanks RBCA guidance associated with this rulemaking.

COMMENT #2: Carol Eighmey stated that much duplicative, inconsistent, or erroneous language in the previous version of the Tanks RBCA guidance has been eliminated or corrected with this update of the guidance, and that this alone makes this rulemaking a worthwhile endeavor.
RESPONSE: The department appreciates Ms. Eighmey's comment in support of this rulemaking.

COMMENT #3: Ms. Eighmey pointed out that the department's proposed rulemaking eliminates the requirement to use standardized forms in various reports, and that this is "a huge improvement." She stated that the requirement to use these standardized forms is now clearly obsolete and that some of the forms are no longer even accurate. Ms. Eighmey indicated that the PSTIF looks forward to the elimination of this requirement.
RESPONSE: The department appreciates Ms. Eighmey's comment in support of this change.

COMMENT #4: Ms. Eighmey stated "the proposed rulemaking *does* impose some new requirements and changes some of the numerical cleanup standards. We have reviewed the proposed changes and – while we're not fans of all of them, and some of them will increase costs – we nevertheless believe they are reasonable and can be implemented without *unduly* increasing costs."
RESPONSE: The department appreciates Ms. Eighmey's understanding and support of the new requirements.

COMMENT #5: Ms. Eighmey stated that what has been accomplished with this rulemaking and guidance update – "while it undoubtedly falls short of perfect – is a *significant and substantial* step forward, and one that is long overdue."
RESPONSE: The department agrees with Ms. Eighmey's comment and appreciates her support of the rulemaking.

COMMENT #6: Ms. Eighmey stated that the first paragraph in Subsection 1.1 of the updated Tanks RBCA guidance accurately refers to the 2004 RBCA guidance document as "draft guidance." She suggests that the first sentence in the second paragraph of the subsection be revised as follows: "In 2005, the process provided for by the **draft** guidance was modified…"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence of Subsection 1.1 has been changed to read: "In 2005, the process provided for by the draft guidance was modified by the addition of six (6) supplemental guidance documents."

COMMENT #7: Ms. Eighmey stated that the second sentence in Subsection 2.1 of the updated guidance refers to Section 1.3 of the Guidance Document, which will no longer exist. She suggests deleting the phrase, "…as discussed at Section 1.3 of this document…"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of Subsection 2.1 has been revised to read: "The MRBCA process begins when a petroleum release is suspected or discovered and includes all subsequent activities (except those conducted under 260.500 through 260.550 RSMo and the regulations promulgated thereunder) until MDNR issues a 'No Further Action' (NFA) letter for the release."

COMMENT #8: Ms. Eighmey suggests renaming Subsection 2.2.1 of the updated guidance "**Release** Discovery" instead of "Site Discovery," to be consistent with other language in the guidance.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. Subsection 2.2.1 of the updated guidance has been renamed "Release Discovery."

In addition, the department has changed the first sentence of Subsection 2.2.1 of the updated guidance to refer to the discovery of a release at an underground storage tank (UST)/above ground storage tank (AST) site rather than the discovery of "contamination." In addition, "site" also appeared in the second and third sentences of Subsection 2.2.1 as well as the first sentence of the second paragraph of the subsection. Where appropriate, the department has changed the use of "site" in the subsection to "release," as follows:

"The MRBCA process begins with the discovery of a release at a UST/AST site. A release might be discovered and reported to the MDNR under a variety of circumstances including, but not limited to, (i) system closure, (ii) a site check investigation resulting in confirmation of a release, and (iii) identification of an imminent hazard (e.g., vapors in sewers or buildings, etc.). Releases might also be identified during investigations conducted as a part of real estate transactions, investigations conducted in anticipation of land development, and the occurrence of accidents and spills.

The release discovery process should generally result in the identification of affected media at a site and generate analytical data. This initial data should, ideally, represent the point or points of release, the chemicals of concern (COCs), and the maximum concentrations of the COCs."

COMMENT #9: Ms. Eighmey suggests revising the fourth sentence of Subsection 2.4 of the updated guidance as follows, "Such communication must occur throughout the MRBCA process, from **release** discovery to issuance…," to be consistent with other language in the guidance.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The fourth sentence of Subsection 2.4 has been revised to read: "Such communication must occur throughout the MRBCA process, from release discovery to issuance of a NFA letter, so that interested parties can determine if decisions made and activities undertaken during the MRBCA process at a site were sufficient to adequately protect human health and the environment."

COMMENT #10: Ms. Eighmey suggests revising the first sentence of the second paragraph of Subsection 3.1 of the updated guidance as follows: "…may ultimately lead to *[site]* discovery **of a release**."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence of the second paragraph of Subsection 3.1 has been revised to read: "A number of different events may trigger site-specific activities that may ultimately lead to release discovery."

COMMENT #11: Ms. Eighmey stated that, since an explicit list of required photographs is being added to the guidance, the previous, less-precise sentence toward the end of Subsection 4.4.1 that says, "During the tank closure process, sufficient color photographs shall be collected to document the condition of tanks, excavation, pads, etc., and submitted with the closure report" should be deleted.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts the comment. The second-to-last sentence in Subsection 4.4.1 has been deleted from the updated guidance.

COMMENT #12: Ms. Eighmey suggests revising Subsection 4.5.8 of the updated guidance to more accurately describe current practices, as follows: "If treatment will be via on-site landfarming, **approval must be obtained from MDNR's Tanks Section as part of the Corrective Action Plan (CAP) for the petroleum release. Off-site landfarms require a permit issued by MDNR's Water Protection Program (WPP); f**or information *[concerning landfarm permits,]* contact MDNR's WPP at …"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of Subsection 4.5.8 has been revised to read: "If treatment will be via on-site landfarming, approval must be obtained from MDNR's Tanks Section as part of the CAP for the petroleum release. Off-site landfarms require a permit issued by MDNR's WPP; for information, contact MDNR's WPP at (573) 751-1300."

COMMENT #13: Ms. Eighmey suggests revising the last item in the third bulleted list of Subsection 5.1 to be consistent with change to terminology made throughout the document, as follows: "Information about corrective action measures *[or risk management activities]* that have been conducted and are planned."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The last item in the third bulleted list has been revised to read: "Information about corrective action

measures that have been conducted and are planned."

COMMENT #14: Also in Subsection 5.1, Ms. Eighmey suggests revising the first sentence of the paragraph following the third bulleted list as follows: "…beyond that discussed herein might be required to develop a **Corrective Action Plan** or to complete a Tier 3…"

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence in the paragraph following the third bulleted list in Subsection 5.1 has been revised to read: "Note: Additional data beyond that discussed herein might be required to develop a Corrective Action Plan (CAP) or to complete a Tier 3 risk assessment."

COMMENT #15: Ms. Eighmey states that the first paragraph of Subsection 5.2 of the updated guidance appears to have been written in 2004 to help owners and their consultants understand how to transition to the new MRBCA Guidance. She indicates that the paragraph is largely obsolete today and – as a summary of the RBCA process – discusses in a general way the tasks that are more specifically presented throughout the document. Ms. Eighmey suggests deleting the entire paragraph.

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment in part. The department believes some of the language in the first paragraph of Subsection 5.2 is valuable and therefore should be retained. The paragraph has been revised to read as follows: "As part of the MRBCA evaluation, the person undertaking the evaluation must carefully review all existing data and identify any data gaps. Only after all the necessary data have been collected and full site characterization is complete should the person undertaking the evaluation proceed with the development of target levels."

COMMENT #16: Ms. Eighmey points out that the second paragraph of Subsection 5.4.5 of the updated guidance references MEGA, a compilation of data that is now obsolete. She suggests revising the paragraph as follows: "Two (2) valuable sources of regional hydrogeology and aquifer characteristic information are the Well Information System, which contains all records of known wells in Missouri and is available at http://dnr.mo.gov/mowells/publicLanding.do, and "CARES" maps, available at http://ims.missouri.edu/moims/step1.aoi/countylist.asp."

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second paragraph of Subsection 5.4.5 has been revised to read: "Two (2) valuable sources of regional hydrogeology and aquifer characteristic information are the Well Information System, which contains all records of known wells in Missouri and is available at http://dnr.mo.gov/mowells/publicLanding.do, and Center for Applied Research and Environmental Systems or "CARES" maps, available at http://ims.missouri.edu/moims/step1.aoi/countylist.asp."

COMMENT #17: Ms. Eighmey states that the last paragraph of the text added to Subsection 5.6.4 as part of the guidance update advises the reader to "refer to Subsection 5.8 for developing a sampling plan for VWC." She indicates that, though Subsection 5.8 contains helpful information for designing one's sampling plan, it is not specific to volumetric water content (VWC). Ms. Eighmey suggests deleting the words "for VWC" from the text in Subsection 5.6.4.

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The last paragraph of Subsection 5.6.4 has been revised to read: "Refer to Subsection 5.8 for developing a sampling plan. Because VWC varies over time most significantly in surficial soil, VWC data should not be collected from surficial soil (i.e., 0 – 3') except when the foundation of an existing building is less than three feet (3') deep."

COMMENT #18: Ms. Eighmey states that Subsection 5.9.1 conflicts with information contained in Subsection 6.3.3 regarding point of demonstration (POD) and point of exposure (POE). She suggests that the subsection be revised accordingly.

RESPONSE: The department does not agree that the two (2) subsections are in conflict, because Subsection 5.9.1 pertains to delineation of contaminants in groundwater whereas Subsection 6.3.3 pertains to the evaluation of the groundwater use pathway. Therefore, no change is proposed.

COMMENT #19: Ms. Eighmey comments that the department accepts Method 3511 for total petroleum hydrocarbons-diesel range organics (TPH-DRO), as long as the lab meets the same detection limits and quality assurance/quality control (QA/QC) requirements as for other methods. She suggests that Method 3511 be added to Table 5-1 as an option for TPH-DRO.

RESPONSE: The department does not accept Ms. Eighmey's comment. Method 3511 is a micro-extraction procedure; it is not an analysis procedure to quantify concentrations of COCs. The information in Table 5-1 includes analysis procedures. While the Tanks Section has approved the use of Method 3511, the guidance is not structured to include such extraction methods, but rather only analytical methods. Therefore, the department has not made the suggested addition.

COMMENT #20: Ms. Eighmey suggests that the following sentence be inserted into the updated guidance at the end of Subsection 6.1.2.1: "Because petroleum equipment companies are subject to other regulatory requirements regarding worker exposure, it is not necessary to evaluate dermal contact risk associated with soil or groundwater exposures in the areas of the property where tanks/piping are located."

RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the essence of Ms. Eighmey's comment, but not all of the suggested language. The subject of the comment was also the subject of a July 3, 2013, memorandum from Aaron Schmidt of the department to which Ms. Eighmey referred in her oral comments to the Hazardous Waste Management Commission at the August 15, 2013, public hearing regarding the subject rule amendments and updated guidance. In that memorandum, the scope of the exception described in the memo and Ms. Eighmey's comment is limited to the tank pit as defined in the memorandum. The department intends for the language to be added at the end of Subsection 6.1.2.1 to reflect the scope defined in the memorandum. Therefore, in response to this comment, the department has inserted the following language at the end of Subsection 6.1.2.1: "Because petroleum equipment companies are subject to other regulatory requirements regarding worker exposure, it is not necessary to evaluate the soil ingestion, inhalation, and dermal contact exposure pathway nor the dermal contact with groundwater exposure pathway for the construction worker receptor in the area in which an active underground storage tank (i.e., the tank pit) is located."

COMMENT #21: Ms. Eighmey suggests inserting the following sentence at the end of Subsection 6.1.3.1: "At an active tank facility, the exposure model can assume no building will be constructed over the tank pit or where the dispensers are located."

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment in part. The subject of the comment was also the subject of a July 3, 2013, memorandum from Aaron Schmidt of the department to which Ms. Eighmey referred in her oral comments to the Hazardous Waste Management Commission at the August 15, 2013, public hearing regarding the subject rule amendments and updated guidance. With respect to the exposure model limitation, the memorandum states "When evaluating the indoor inhalation of vapors exposure pathways for soil and groundwater for a future residential or non-residential land use scenario, the tank pit need not be included in the evaluation. All areas outside of the tank pit shall be included in the evaluation." The department has not incorporated Ms. Eighmey's suggested language "where the dispensers are located"

into the subsection because the memorandum applies only to the tank pit. The department intends for the language added at the end of Subsection 6.1.3.1 to be consistent with Mr. Schmidt's memorandum. Therefore, the department has added the following language to the end of Subsection 6.1.3.1: "The exposure model for an active tank facility may assume that no building will be constructed over the tank pit."

COMMENT #22: So that the text will match the terminology used in Table 7-4, Ms. Eighmey suggests that the third paragraph of Subsection 7.5 of the updated guidance be revised as follows: "Depending on this distance **and the depth** to groundwater…,"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of the third paragraph of Subsection 7.5 has been revised to read: "Depending on this distance and the depth to groundwater, as discussed above, soil concentrations protective of groundwater will be selected from Tables 7-4(a), 7-4(b), or 7-4(c)."

COMMENT #23: Ms. Eighmey states that the text added (during updating of the guidance) just before Subsection 9.1 references "light non-aqueous phase liquid" and "LNAPL" in several places. She asks whether this paragraph should use the term "free product" instead of "light non-aqueous phase liquid" or "LNAPL."
RESPONSE: The department feels the use of "LNAPL" rather than "free product" is appropriate in the paragraphs just before Subsection 9.1 because the analytical limitations that necessitate the requirements stated in the paragraphs pertain equally to both mobile (i.e., "free product") and immobile LNAPL. In the experience of the department, analytical laboratories frequently refrain from analyzing grossly contaminated samples (i.e., samples with mobile and/or immobile LNAPL) because such samples can result in equipment being out of use for extended periods due to the need to thoroughly clean the equipment and due to the difficulty in accurately quantifying all chemicals of concern in such samples. The latter is due to the need to dilute such samples such that the detection limits for some of the COCs are elevated to a degree that the concentrations of the chemicals cannot be meaningfully quantified. Therefore, the department has not made any change to the paragraphs immediately preceding Subsection 9.1.

COMMENT #24: Ms. Eighmey states that the second bulleted list in Subsection 10.1 contains two (2) references to "LNAPL" in two (2) places. She suggests deleting the first reference and changing the second to "free product."
RESPONSE AND EXPLANATION OF CHANGE: The department does not agree with Ms. Eighmey's suggestions. The sentence preceding the second bulleted list in Subsection 10.1 reads: "The overall objective of a [Corrective Action Plan] is to ensure that:" The third bullet thereafter correctly explains the conditions related to LNAPL and free product that the Corrective Action Plan is to address or prevent. However, upon review, the department finds the language in the third bullet of the second bulleted list in Subsection 10.1 is unclear with regard to whether the conditions stated there pertain to LNAPL, free product, or both.

To ensure the requirements of Subsection 10.1 are clear, the department has revised the language of the third bullet in the second bulleted list in the subsection to read as follows: "Mobile or immobile light non-aqueous phase liquids (LNAPL; mobile LNAPL is referred to as "free product") are not present in the soil or groundwater in volumes that will result in any of the following conditions: (i) an expanding free product plume in soil or groundwater, (ii) an expanding dissolved plume, (iii) unacceptable risk to human health or the environment, and (iv) explosive or fire hazard."

These changes are based on the Department's contention that an expanding dissolved phase contaminant plume and unacceptable risk to human health or the environment could be caused by either LNAPL or free product. We contend that the same is arguably true with respect to the creation of an explosion or fire hazard as well. However, we acknowledge that only free product is subject to migration and therefore have replaced "LNAPL" at (i) with "free product."

COMMENT #25: Ms. Eighmey comments that the numbering of the footnotes in Appendix C of the updated guidance may need to be corrected.
RESPONSE: The department thanks Ms. Eighmey for the comment and has ensured that the numbering of the footnotes is correct.

COMMENT #26: Mr. Greenwalt stated that, overall, he has no major concerns with what the new rules or Tanks RBCA guidance document contain and that he believes the department, the Petroleum Storage Tank Insurance Fund, and the Missouri Petroleum Marketers and Convenience Store Association put forth a great effort to collaborate and compromise on a streamlined document that will hopefully make the RBCA process less cumbersome and help facilitate site closures. Mr. Greenwalt further stated that, while this latest version of the RBCA guidance might not be perfect, it is clearly an improvement over the previous version of the guidance based on the consolidation and elimination of redundancy and useless requirements.
RESPONSE: The department appreciates Mr. Greenwalt's support of this rulemaking effort.

COMMENT #27: Mr. Greenwalt stated that he has a few comments on the requirements contained in Subsection 6.1.1.2 (Determination of Reasonably Anticipated Future Land Use (RAFU)) of the updated RBCA guidance and, more importantly, the administration of this particular section by the department's project managers. He goes on to say that he is not strongly opposed to the addition of "interviews with property owners" to the list of factors in Subsection 6.1.1.2 that may be used to determine the RAFU of a property, but rather that he disagrees with the disproportionate amount of weight given to this factor by the department's project managers.
RESPONSE: Most of the comments submitted by Mr. Greenwalt pertain to how the department implements those parts of the guidance pertaining to RAFU decisions – in particular how information from property owners is gathered and managed – rather than to the language of the amended rules or the updated guidance themselves. Rulemaking public comment periods, including the comment period for this rulemaking, provide the public with an opportunity to submit comments in support, comments in opposition, or comments suggesting edits to the specific proposed rules and any material to be incorporated by reference. Mr. Greenwalt's comments pertaining to the department's implementation of the guidance to be incorporated by reference are therefore outside of the scope of the rulemaking and the department has not responded to those in this order of rulemaking. In addition, in his comments, Mr. Greenwalt does not suggest any changes to the rules or the updated guidance document.

COMMENT #28: Mr. Greenwalt states that, although the updated Tanks RBCA guidance document has not been accepted by the Hazardous Waste Commission, some of the department's project managers have, for some time, been requiring (not simply requesting) that information regarding future property use be obtained from current property owners.
RESPONSE: The statement "interviews with property owners" in Subsection 6.1.1.2 of the updated Tanks RBCA guidance is not new language; the same language appeared in Subsection 5.5.2 of the 2004 version of the Tanks RBCA guidance. Along with other information in Subsection 5.5.2 of the 2004 guidance, the statement "interviews with property owners" was moved to Subsection 6.1.1.2 of the updated guidance in order to consolidate in Section 6 information related to RAFU.

COMMENT #29: Mr. Jordan commended the department for its efforts to develop a broad consensus on complex and difficult topics.

RESPONSE: The department thanks Mr. Jordan for his comment.

COMMENT #30: Mr. Jordan stated that his sole comment pertains to Subsection 6.1.1.2 of the updated Tanks RBCA guidance. He suggested that "interviews with current property owners" be deleted from the subsection and replaced by "information obtained from current property owners by the consultant or the responsible party."
RESPONSE: The department does not agree with Mr. Jordan's suggestion because the suggested language would limit the department's ability to obtain information from current property owners. The department believes it is both reasonable and appropriate for its project managers to gather information from property owners, whether in lieu of a consultant or responsible party or in order to verify information submitted by a consultant or responsible party. The department's role of overseeing RBCA evaluations includes verifying information submitted by consultants by contacting or finding other, additional sources of information.

In addition, the statement "interviews with property owners" in Subsection 6.1.1.2 of the updated Tanks RBCA guidance is not new language; the same language appeared in Subsection 5.5.2 of the 2004 version of the Tanks RBCA guidance. Along with other information in Subsection 5.5.2 of the 2004 guidance, the statement "interviews with property owners" was moved to Subsection 6.1.1.2 of the updated guidance in order to consolidate in Section 6 information related to RAFU.

COMMENT #31: Mr. Leone stated that the Missouri Petroleum Marketers & Convenience Store Association (MPCA) "fully supports and incorporates herein by reference both the written comments being submitted by Mark Jordan & Donnie Greenwalt with Wallis Companies and the 8/15/13 public testimony presented by the Petroleum Storage Tank Insurance Fund (PSTIF)."
RESPONSE: The department's responses to the comments submitted by Mr. Greenwalt, Mr. Jordan, and Ms. Eighmey are contained within this order of rulemaking.

COMMENT #32: Mr. Leone stated that "MPCA believes the proposed RBCA rule changes are for the most part necessary, reasonable [and] measured, and we ask that you seriously consider the comments and suggestions provided by both PSTIF and Wallis Companies."
RESPONSE: The department thanks Mr. Leone for the comment. The department has given serious consideration to all of the comments submitted and has provided a response to each in this order of rulemaking.

COMMENT #33: Mr. Leone thanked department staff for their hard work to develop the amendments and update the Tanks RBCA guidance.
RESPONSE: The department thanks Mr. Leone for his comments recognizing the work of department staff in relation to this rulemaking.

10 CSR 26-2.078 Investigations for Soil and Groundwater Cleanup

(3) Owners and operators shall follow a written procedure.

(C) Written Procedures.

1. *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks* guidance document, October 17, 2013, which is hereby incorporated by reference without any subsequent amendments or additions, and is published by the Department of Natural Resources, PO Box 176, Jefferson City, MO 65102-0176.

2. *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks*, February 2004, as amended March 8, 2005, by *Notice of Modifications to the Process and Interim Guidance Pertaining to Application of the New Soil Type Dependent Tier 1 Risk-Based Target Levels*; the March 18, 2005, *Soil Type Determination Guidelines*; the March 3, 2005, Table 3-1 Default Target Levels; the April 2005 Table 4-1 Soil Concentration Levels to Determine the Need for Groundwater Evaluation During Tank Closure; the February 2005 Tables 7-1(a) through 7-12(c) Tier 1 Risk-Based Target Levels; and the April 21, 2005, *Soil Gas Sampling Protocol*, which are hereby incorporated by reference without any subsequent amendments or additions, and are published by the Department of Natural Resources, PO Box 176, Jefferson City, MO 65102-0176.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 26—Petroleum and Hazardous Substance Storage Tanks
Chapter 2—Underground Storage Tanks—Technical Regulations

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission (commission) under sections 319.109 and 319.137, RSMo Supp. 2013, the commission hereby amends a rule as follows:

10 CSR 26-2.082 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2013 (38 MoReg 1162–1163). Those sections with changes are reprinted here. Additionally, the incorporated by reference material has been changed as a result of comments. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on August 15, 2013, and the public comment period ended on August 22, 2013. The Missouri Department of Natural Resources' Hazardous Waste Program received thirty-three (33) comments regarding the guidance document proposed for incorporation by reference at paragraph (5)(C)1. of the amended rule. The comments came from five (5) sources, as follows: Brian Porter, Terracon; Carol Eighmey, Petroleum Storage Tank Insurance Fund; Donnie Greenwalt, Wallis Companies; Mark Jordan, Wallis Companies; and Ron Leone, Missouri Petroleum Marketers and Convenience Store Association. The Hazardous Waste Program did not receive any comments regarding the rule language itself. However, department staff have determined that changes made to the January 1, 2013, version of the *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks* guidance document as a result of comments received during the public comment period necessitate that the date of the guidance be changed in the rule in order to differentiate the final guidance from the January 1, 2013, version. The department proposes to revise paragraph (5)(C)1. of 10 CSR 26-2.082 to reflect a guidance publication date of October 17, 2013.

COMMENT #1: Brian Porter stated the following: "One of the main reasons for revising the tanks Missouri Risk-Based Corrective Action (MRBCA) guidance was a desire to update its risk-based levels with the most current toxicological data and scientific methodology utilized by the Environmental Protection Agency (EPA) and other federal and state agencies. The result would be consistent target levels for Missouri's tanks and Brownfield Voluntary Cleanup Program (B/VCP) that are in line with the most current information used throughout the country.

The proposed updates to the tanks guidance include revisions to the target levels so that they are consistent with the departmental [MRBCA] target levels currently in use. However, we understand that a forthcoming update to the departmental guidance will further update its target levels. If the updates to the tanks guidance occur as

currently scheduled, Missouri's guidance documents will contain consistent target levels for only a very brief period (a matter of months at most). Thereafter, the guidance documents will conflict with each other once again.

Acknowledging that the tanks guidance process has been delayed several times already, it seems prudent to delay it one more time so that both it and the departmental guidance can benefit from the latest toxicological and scientific methodology."

RESPONSE: Mr. Porter's understanding regarding the department's updating of the Departmental Risk-Based Target Levels (RBTLs) is correct; the department has begun that effort and expects draft updated RBTLs to be developed by the end of 2013. Sometime thereafter, the draft RBTLs will be the subject of a sixty- (60-) day public comment period. Mr. Porter is also correct in his statement that the department's updating of the departmental RBTLs will result in those RBTLs differing from the RBTLs in the Tanks Risk-Based Corrective Action (RBCA) guidance.

The RBTLs in the updated Tanks RBCA guidance are based on methodology and toxicity and other inputs that were current in 2009. While the department is aware that the methodology and inputs have changed since that time, and despite the department's preference that the RBTLs in both RBCA documents be the same, the updated Tanks RBCA guidance associated with this rulemaking is the result of protracted negotiations between the department and tanks stakeholders during 2012 and early 2013. Those negotiations resulted in all parties agreeing to move ahead with the 2009 RBTLs. As the department's efforts to revise the departmental RBTLs have only recently begun, and we cannot ensure that the update will be completed on the anticipated schedule, the department will move ahead with the 2009 RBTLs (that are consistent with the current departmental RBTLs) that are found in the Tanks RBCA guidance associated with this rulemaking.

COMMENT #2: Carol Eighmey stated that much duplicative, inconsistent, or erroneous language in the previous version of the Tanks RBCA guidance has been eliminated or corrected with this update of the guidance, and that this alone makes this rulemaking a worthwhile endeavor.

RESPONSE: The department appreciates Ms. Eighmey's comment in support of this rulemaking.

COMMENT #3: Ms. Eighmey pointed out that the department's proposed rulemaking eliminates the requirement to use standardized forms in various reports, and that this is "a huge improvement." She stated that the requirement to use these standardized forms is now clearly obsolete and that some of the forms are no longer even accurate. Ms. Eighmey indicated that the PSTIF looks forward to the elimination of this requirement.

RESPONSE: The department appreciates Ms. Eighmey's comment in support of this change.

COMMENT #4: Ms. Eighmey stated "the proposed rulemaking *does* impose some new requirements and changes some of the numerical cleanup standards. We have reviewed the proposed changes and – while we're not fans of all of them, and some of them will increase costs – we nevertheless believe they are reasonable and can be implemented without *unduly* increasing costs."

RESPONSE: The department appreciates Ms. Eighmey's understanding and support of the new requirements.

COMMENT #5: Ms. Eighmey stated that what has been accomplished with this rulemaking and guidance update – "while it undoubtedly falls short of perfect – is a *significant and substantial* step forward, and one that is long overdue."

RESPONSE: The department agrees with Ms. Eighmey's comment and appreciates her support of the rulemaking.

COMMENT #6: Ms. Eighmey stated that the first paragraph in Subsection 1.1 of the updated Tanks RBCA guidance accurately refers to the 2004 RBCA guidance document as "draft guidance." She suggests that the first sentence in the second paragraph of the subsection be revised as follows: "In 2005, the process provided for by the **draft** guidance was modified…"

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence of Subsection 1.1 has been changed to read: "In 2005, the process provided for by the draft guidance was modified by the addition of six (6) supplemental guidance documents."

COMMENT #7: Ms. Eighmey stated that the second sentence in Subsection 2.1 of the updated guidance refers to Section 1.3 of the Guidance Document, which will no longer exist. She suggests deleting the phrase, "…as discussed at Section 1.3 of this document…"

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of Subsection 2.1 has been revised to read: "The MRBCA process begins when a petroleum release is suspected or discovered and includes all subsequent activities (except those conducted under 260.500 through 260.550 RSMo and the regulations promulgated thereunder) until MDNR issues a 'No Further Action' (NFA) letter for the release."

COMMENT #8: Ms. Eighmey suggests renaming Subsection 2.2.1 of the updated guidance "**Release** Discovery" instead of "Site Discovery," to be consistent with other language in the guidance.

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. Subsection 2.2.1 of the updated guidance has been renamed "Release Discovery."

In addition, the department has changed the first sentence of Subsection 2.2.1 of the updated guidance to refer to the discovery of a release at an underground storage tank (UST)/above ground storage tank (AST) site rather than the discovery of "contamination." In addition, "site" also appeared in the second and third sentences of Subsection 2.2.1 as well as the first sentence of the second paragraph of the subsection. Where appropriate, the department has changed the use of "site" in the subsection to "release," as follows:

"The MRBCA process begins with the discovery of a release at a UST/AST site. A release might be discovered and reported to the MDNR under a variety of circumstances including, but not limited to, (i) system closure, (ii) a site check investigation resulting in confirmation of a release, and (iii) identification of an imminent hazard (e.g., vapors in sewers or buildings, etc.). Releases might also be identified during investigations conducted as a part of real estate transactions, investigations conducted in anticipation of land development, and the occurrence of accidents and spills.

The release discovery process should generally result in the identification of affected media at a site and generate analytical data. This initial data should, ideally, represent the point or points of release, the chemicals of concern (COCs), and the maximum concentrations of the COCs."

COMMENT #9: Ms. Eighmey suggests revising the fourth sentence of Subsection 2.4 of the updated guidance as follows, "Such communication must occur throughout the MRBCA process, from **release** discovery to issuance…," to be consistent with other language in the guidance.

RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The fourth sentence of Subsection 2.4 has been revised to read: "Such communication must occur throughout the MRBCA process, from release discovery to issuance of a NFA letter, so that interested parties can determine if decisions made and activities undertaken during the MRBCA process at a site were sufficient to adequately protect human health and the environment."

COMMENT #10: Ms. Eighmey suggests revising the first sentence of the second paragraph of Subsection 3.1 of the updated guidance as

follows: "…may ultimately lead to *[site]* discovery **of a release**."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence of the second paragraph of Subsection 3.1 has been revised to read: "A number of different events may trigger site-specific activities that may ultimately lead to release discovery."

COMMENT #11: Ms. Eighmey stated that, since an explicit list of required photographs is being added to the guidance, the previous, less-precise sentence toward the end of Subsection 4.4.1 that says, "During the tank closure process, sufficient color photographs shall be collected to document the condition of tanks, excavation, pads, etc., and submitted with the closure report" should be deleted.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts the comment. The second-to-last sentence in Subsection 4.4.1 has been deleted from the updated guidance.

COMMENT #12: Ms. Eighmey suggests revising Subsection 4.5.8 of the updated guidance to more accurately describe current practices, as follows: "If treatment will be via on-site landfarming, **approval must be obtained from MDNR's Tanks Section as part of the Corrective Action Plan (CAP) for the petroleum release. Off-site landfarms require a permit issued by MDNR's Water Protection Program (WPP); f**or information *[concerning landfarm permits,]* contact MDNR's WPP at …"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of Subsection 4.5.8 has been revised to read: "If treatment will be via on-site landfarming, approval must be obtained from MDNR's Tanks Section as part of the CAP for the petroleum release. Off-site landfarms require a permit issued by MDNR's WPP; for information, contact MDNR's WPP at (573) 751-1300."

COMMENT #13: Ms. Eighmey suggests revising the last item in the third bulleted list of Subsection 5.1 to be consistent with change to terminology made throughout the document, as follows: "Information about corrective action measures *[or risk management activities]* that have been conducted and are planned."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The last item in the third bulleted list has been revised to read: "Information about corrective action measures that have been conducted and are planned."

COMMENT #14: Also in Subsection 5.1, Ms. Eighmey suggests revising the first sentence of the paragraph following the third bulleted list as follows: "…beyond that discussed herein might be required to develop a **Corrective Action Plan** or to complete a Tier 3…"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The first sentence in the paragraph following the third bulleted list in Subsection 5.1 has been revised to read: "Note: Additional data beyond that discussed herein might be required to develop a Corrective Action Plan (CAP) or to complete a Tier 3 risk assessment."

COMMENT #15: Ms. Eighmey states that the first paragraph of Subsection 5.2 of the updated guidance appears to have been written in 2004 to help owners and their consultants understand how to transition to the new MRBCA Guidance. She indicates that the paragraph is largely obsolete today and – as a summary of the RBCA process – discusses in a general way the tasks that are more specifically presented throughout the document. Ms. Eighmey suggests deleting the entire paragraph.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment in part. The department believes some of the language in the first paragraph of Subsection 5.2 is valuable and therefore should be retained. The paragraph has been revised to read as follows: "As part of the MRBCA evaluation, the person undertaking the evaluation must carefully review all existing data and identify any data gaps. Only after all the necessary data have been collected and full site characterization is complete should the person undertaking the evaluation proceed with the development of target levels."

COMMENT #16: Ms. Eighmey points out that the second paragraph of Subsection 5.4.5 of the updated guidance references MEGA, a compilation of data that is now obsolete. She suggests revising the paragraph as follows: "Two (2) valuable sources of regional hydrogeology and aquifer characteristic information are the Well Information System, which contains all records of known wells in Missouri and is available at http://dnr.mo.gov/mowells/publicLanding.do, and "CARES" maps, available at http://ims.missouri.edu/moims/step1.aoi/countylist.asp."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second paragraph of Subsection 5.4.5 has been revised to read: "Two (2) valuable sources of regional hydrogeology and aquifer characteristic information are the Well Information System, which contains all records of known wells in Missouri and is available at http://dnr.mo.gov/mowells/publicLanding.do, and Center for Applied Research and Environmental Systems or "CARES" maps, available at http://ims.missouri.edu/moims/step1.aoi/countylist.asp."

COMMENT #17: Ms. Eighmey states that the last paragraph of the text added to Subsection 5.6.4 as part of the guidance update advises the reader to "refer to Subsection 5.8 for developing a sampling plan for VWC." She indicates that, though Subsection 5.8 contains helpful information for designing one's sampling plan, it is not specific to volumetric water content (VWC). Ms. Eighmey suggests deleting the words "for VWC" from the text in Subsection 5.6.4.
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The last paragraph of Subsection 5.6.4 has been revised to read: "Refer to Subsection 5.8 for developing a sampling plan. Because VWC varies over time most significantly in surficial soil, VWC data should not be collected from surficial soil (i.e., 0 – 3') except when the foundation of an existing building is less than three feet (3') deep."

COMMENT #18: Ms. Eighmey states that Subsection 5.9.1 conflicts with information contained in Subsection 6.3.3 regarding point of demonstration (POD) and point of exposure (POE). She suggests that the subsection be revised accordingly.
RESPONSE: The department does not agree that the two (2) subsections are in conflict, because Subsection 5.9.1 pertains to delineation of contaminants in groundwater whereas Subsection 6.3.3 pertains to the evaluation of the groundwater use pathway. Therefore, no change is proposed.

COMMENT #19: Ms. Eighmey comments that the department accepts Method 3511 for total petroleum hydrocarbons-diesel range organics (TPH-DRO), as long as the lab meets the same detection limits and quality assurance/quality control (QA/QC) requirements as for other methods. She suggests that Method 3511 be added to Table 5-1 as an option for TPH-DRO.
RESPONSE: The department does not accept Ms. Eighmey's comment. Method 3511 is a micro-extraction procedure; it is not an analysis procedure to quantify concentrations of COCs. The information in Table 5-1 includes analysis procedures. While the Tanks Section has approved the use of Method 3511, the guidance is not structured to include such extraction methods, but rather only analytical methods. Therefore, the department has not made the suggested addition.

COMMENT #20: Ms. Eighmey suggests that the following sentence be inserted into the updated guidance at the end of Subsection 6.1.2.1: "Because petroleum equipment companies are subject to other regulatory requirements regarding worker exposure, it is not

necessary to evaluate dermal contact risk associated with soil or groundwater exposures in the areas of the property where tanks/piping are located."
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the essence of Ms. Eighmey's comment, but not all of the suggested language. The subject of the comment was also the subject of a July 3, 2013, memorandum from Aaron Schmidt of the department to which Ms. Eighmey referred in her oral comments to the Hazardous Waste Management Commission at the August 15, 2013, public hearing regarding the subject rule amendments and updated guidance. In that memorandum, the scope of the exception described in the memo and Ms. Eighmey's comment is limited to the tank pit as defined in the memorandum. The department intends for the language to be added at the end of Subsection 6.1.2.1 to reflect the scope defined in the memorandum. Therefore, in response to this comment, the department has inserted the following language at the end of Subsection 6.1.2.1: "Because petroleum equipment companies are subject to other regulatory requirements regarding worker exposure, it is not necessary to evaluate the soil ingestion, inhalation, and dermal contact exposure pathway nor the dermal contact with groundwater exposure pathway for the construction worker receptor in the area in which an active underground storage tank (i.e., the tank pit) is located."

COMMENT #21: Ms. Eighmey suggests inserting the following sentence at the end of Subsection 6.1.3.1: "At an active tank facility, the exposure model can assume no building will be constructed over the tank pit or where the dispensers are located."
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment in part. The subject of the comment was also the subject of a July 3, 2013, memorandum from Aaron Schmidt of the department to which Ms. Eighmey referred in her oral comments to the Hazardous Waste Management Commission at the August 15, 2013, public hearing regarding the subject rule amendments and updated guidance. With respect to the exposure model limitation, the memorandum states "When evaluating the indoor inhalation of vapors exposure pathways for soil and groundwater for a future residential or non-residential land use scenario, the tank pit need not be included in the evaluation. All areas outside of the tank pit shall be included in the evaluation." The department has not incorporated Ms. Eighmey's suggested language "where the dispensers are located" into the subsection because the memorandum applies only to the tank pit. The department intends for the language added at the end of Subsection 6.1.3.1 to be consistent with Mr. Schmidt's memorandum. Therefore, the department has added the following language to the end of Subsection 6.1.3.1: "The exposure model for an active tank facility may assume that no building will be constructed over the tank pit."

COMMENT #22: So that the text will match the terminology used in Table 7-4, Ms. Eighmey suggests that the third paragraph of Subsection 7.5 of the updated guidance be revised as follows: "Depending on this distance **and the depth** to groundwater…,"
RESPONSE AND EXPLANATION OF CHANGE: The department accepts Ms. Eighmey's comment. The second sentence of the third paragraph of Subsection 7.5 has been revised to read: "Depending on this distance and the depth to groundwater, as discussed above, soil concentrations protective of groundwater will be selected from Tables 7-4(a), 7-4(b), or 7-4(c)."

COMMENT #23: Ms. Eighmey states that the text added (during updating of the guidance) just before Subsection 9.1 references "light non-aqueous phase liquid" and "LNAPL" in several places. She asks whether this paragraph should use the term "free product" instead of "light non-aqueous phase liquid" or "LNAPL."
RESPONSE: The department feels the use of "LNAPL" rather than "free product" is appropriate in the paragraphs just before Subsection 9.1 because the analytical limitations that necessitate the requirements stated in the paragraphs pertain equally to both mobile (i.e., "free product") and immobile LNAPL. In the experience of the department, analytical laboratories frequently refrain from analyzing grossly contaminated samples (i.e., samples with mobile and/or immobile LNAPL) because such samples can result in equipment being out of use for extended periods due to the need to thoroughly clean the equipment and due to the difficulty in accurately quantifying all chemicals of concern in such samples. The latter is due to the need to dilute such samples such that the detection limits for some of the COCs are elevated to a degree that the concentrations of the chemicals cannot be meaningfully quantified. Therefore, the Department has not made any change to the paragraphs immediately preceding Subsection 9.1.

COMMENT #24: Ms. Eighmey states that the second bulleted list in Subsection 10.1 contains two (2) references to "LNAPL" in two (2) places. She suggests deleting the first reference and changing the second to "free product."
RESPONSE AND EXPLANATION OF CHANGE: The department does not agree with Ms. Eighmey's suggestions. The sentence preceding the second bulleted list in Subsection 10.1 reads: "The overall objective of a [Corrective Action Plan] is to ensure that:" The third bullet thereafter correctly explains the conditions related to LNAPL and free product that the Corrective Action Plan is to address or prevent. However, upon review, the department finds the language in the third bullet of the second bulleted list in Subsection 10.1 is unclear with regard to whether the conditions stated there pertain to LNAPL, free product, or both.

To ensure the requirements of Subsection 10.1 are clear, the department has revised the language of the third bullet in the second bulleted list in the subsection to read as follows: "Mobile or immobile light non-aqueous phase liquids (LNAPL; mobile LNAPL is referred to as "free product") are not present in the soil or groundwater in volumes that will result in any of the following conditions: (i) an expanding free product plume in soil or groundwater, (ii) an expanding dissolved plume, (iii) unacceptable risk to human health or the environment, and (iv) explosive or fire hazard."

These changes are based on the department's contention that an expanding dissolved phase contaminant plume and unacceptable risk to human health or the environment could be caused by either LNAPL or free product. We contend that the same is arguably true with respect to the creation of an explosion or fire hazard as well. However, we acknowledge that only free product is subject to migration and therefore have replaced "LNAPL" at (i) with "free product."

COMMENT #25: Ms. Eighmey comments that the numbering of the footnotes in Appendix C of the updated guidance may need to be corrected.
RESPONSE: The department thanks Ms. Eighmey for the comment and has ensured that the numbering of the footnotes is correct.

COMMENT #26: Mr. Greenwalt stated that, overall, he has no major concerns with what the new rules or Tanks RBCA guidance document contain and that he believes the department, the Petroleum Storage Tank Insurance Fund, and the Missouri Petroleum Marketers and Convenience Store Association put forth a great effort to collaborate and compromise on a streamlined document that will hopefully make the RBCA process less cumbersome and help facilitate site closures. Mr. Greenwalt further stated that, while this latest version of the RBCA guidance might not be perfect, it is clearly an improvement over the previous version of the guidance based on the consolidation and elimination of redundancy and useless requirements.
RESPONSE: The department appreciates Mr. Greenwalt's support of this rulemaking effort.

COMMENT #27: Mr. Greenwalt stated that he has a few comments on the requirements contained in Subsection 6.1.1.2 (Determination

of Reasonably Anticipated Future Land Use (RAFU)) of the updated RBCA guidance and, more importantly, the administration of this particular section by the department's project managers. He goes on to say that he is not strongly opposed to the addition of "interviews with property owners" to the list of factors in Subsection 6.1.1.2 that may be used to determine the RAFU of a property, but rather that he disagrees with the disproportionate amount of weight given to this factor by the department's project managers.
RESPONSE: Most of the comments submitted by Mr. Greenwalt pertain to how the Department implements those parts of the guidance pertaining to RAFU decisions – in particular how information from property owners is gathered and managed – rather than to the language of the amended rules or the updated guidance themselves. Rulemaking public comment periods, including the comment period for this rulemaking, provide the public with an opportunity to submit comments in support, comments in opposition, or comments suggesting edits to the specific proposed rules and any material to be incorporated by reference. Mr. Greenwalt's comments pertaining to the department's implementation of the guidance to be incorporated by reference are therefore outside of the scope of the rulemaking and the department has not responded to those in this order of rulemaking. In addition, in his comments, Mr. Greenwalt does not suggest any changes to the rules or the updated guidance document.

COMMENT #28: Mr. Greenwalt states that, although the updated Tanks RBCA guidance document has not been accepted by the Hazardous Waste Commission, some of the department's project managers have, for some time, been requiring (not simply requesting) that information regarding future property use be obtained from current property owners.
RESPONSE: The statement "interviews with property owners" in Subsection 6.1.1.2 of the updated Tanks RBCA guidance is not new language; the same language appeared in Subsection 5.5.2 of the 2004 version of the Tanks RBCA guidance. Along with other information in Subsection 5.5.2 of the 2004 guidance, the statement "interviews with property owners" was moved to Subsection 6.1.1.2 of the updated guidance in order to consolidate in Section 6 information related to RAFU.

COMMENT #29: Mr. Jordan commended the department for its efforts to develop a broad consensus on complex and difficult topics.
RESPONSE: The department thanks Mr. Jordan for his comment.

COMMENT #30: Mr. Jordan stated that his sole comment pertains to Subsection 6.1.1.2 of the updated Tanks RBCA guidance. He suggested that "interviews with current property owners" be deleted from the subsection and replaced by "information obtained from current property owners by the consultant or the responsible party."
RESPONSE: The department does not agree with Mr. Jordan's suggestion because the suggested language would limit the department's ability to obtain information from current property owners. The department believes it is both reasonable and appropriate for its project managers to gather information from property owners, whether in lieu of a consultant or responsible party or in order to verify information submitted by a consultant or responsible party. The department's role of overseeing RBCA evaluations includes verifying information submitted by consultants by contacting or finding other, additional sources of information.

In addition, the statement "interviews with property owners" in Subsection 6.1.1.2 of the updated Tanks RBCA guidance is not new language; the same language appeared in Subsection 5.5.2 of the 2004 version of the Tanks RBCA guidance. Along with other information in Subsection 5.5.2 of the 2004 guidance, the statement "interviews with property owners" was moved to Subsection 6.1.1.2 of the updated guidance in order to consolidate in Section 6 information related to RAFU.

COMMENT #31: Mr. Leone stated that the Missouri Petroleum Marketers & Convenience Store Association (MPCA) "fully supports and incorporates herein by reference both the written comments being submitted by Mark Jordan & Donnie Greenwalt with Wallis Companies and the 8/15/13 public testimony presented by the Petroleum Storage Tank Insurance Fund (PSTIF)."
RESPONSE: The department's responses to the comments submitted by Mr. Greenwalt, Mr. Jordan, and Ms. Eighmey are contained within this order of rulemaking.

COMMENT #32: Mr. Leone stated that "MPCA believes the proposed RBCA rule changes are for the most part necessary, reasonable [and] measured, and we ask that you seriously consider the comments and suggestions provided by both PSTIF and Wallis Companies."
RESPONSE: The department thanks Mr. Leone for the comment. The department has given serious consideration to all of the comments submitted and has provided a response to each in this order of rulemaking.

COMMENT #33: Mr. Leone thanked department staff for their hard work to develop the amendments and update the Tanks RBCA guidance.
RESPONSE: The department thanks Mr. Leone for his comments recognizing the work of department staff in relation to this rulemaking.

10 CSR 26-2.082 Corrective Action Plan

(5) Owners and operators shall follow a written procedure.
(C) Written Procedures.
1. *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks* guidance document, October 17, 2013, which is hereby incorporated by reference without any subsequent amendments or additions, and is published by the Department of Natural Resources, PO Box 176, Jefferson City, MO 65102-0176.
2. *Missouri Risk-Based Corrective Action Process for Petroleum Storage Tanks*, February 2004, as amended March 8, 2005, by *Notice of Modifications to the Process and Interim Guidance Pertaining to Application of the New Soil Type Dependent Tier 1 Risk-Based Target Levels*; the March 18, 2005, *Soil Type Determination Guidelines*; the March 3, 2005, Table 3-1 Default Target Levels; the April 2005 Table 4-1 Soil Concentration Levels to Determine the Need for Groundwater Evaluation During Tank Closure; the February 2005 Tables 7-1(a) through 7-12(c) Tier 1 Risk-Based Target Levels; and the April 21, 2005, *Soil Gas Sampling Protocol*, which are hereby incorporated by reference without any subsequent amendments or additions, and are published by the Department of Natural Resources, PO Box 176, Jefferson City, MO 65102-0176.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 14—Approval of Accrediting Organizations for Crime Laboratories

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 650.060 and 650.100, RSMo Supp. 2013, the department adopts a rule as follows:

11 CSR 30-14.010 Approval of Accrediting Organizations for Crime Laboratories **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 16, 2013

(38 MoReg 1486). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 15—Format for Concealed Carry Permits

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 571.101.8, RSMo Supp. 2013, the department adopts a rule as follows:

11 CSR 30-15.010 Format for Concealed Carry Permits **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1391–1393). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 17—School Protection Officers

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 590.190, RSMo Supp. 2013, the director adopts a rule as follows:

11 CSR 75-17.010 Minimum Training Standards for School Protection Officer Training Centers **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2013 (38 MoReg 1549). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 17—School Protection Officers

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 590.190, RSMo Supp. 2013, the director adopts a rule as follows:

11 CSR 75-17.020 Minimum Training Standards for School Protection Officer Training Instructors **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2013 (38 MoReg 1549). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 17—School Protection Officers

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 590.190, RSMo Supp. 2013, the director adopts a rule as follows:

11 CSR 75-17.030 Minimum Training Standards for School Protection Officers **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2013 (38 MoReg 1549–1550). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 17—School Protection Officers

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 590.190, RSMo Supp. 2013, the director adopts a rule as follows:

11 CSR 75-17.040 Minimum Continuing Education Training Standards for School Protection Officers **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2013 (38 MoReg 1550). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

ORDER OF RULEMAKING

By the authority vested in the acting director of revenue under section 301.130, RSMo Supp. 2013, the acting director adopts a rule as follows:

12 CSR 10-23.500 Optional Second Plate for Commercial Motor Vehicles **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2013 (38 MoReg 1550–1552). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 2—Income Maintenance

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services under section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013, the department amends a rule as follows:

13 CSR 40-2.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1393–1394). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Social Services received two (2) comments.

COMMENT #1: The department received a comment which indicated that FSD has no legal authority to exceed federal mandated timeframes for administrative, technological, or other reason, and those exemptions should be removed from the rule.
RESPONSE AND EXPLANATION OF CHANGE: Those exceptions were removed from the rule.

COMMENT #2: The department received a comment which stated that current state policy requires the application to be processed within thirty (30) days for non-disability based Medicaid and that standard should be maintained and included in the regulation.
RESPONSE: Regulation 13 CSR 40-2.010 applies to all applications received by the division. Timelines for the processing of MO HealthNet applications are contained in section 208.072, RSMo.

13 CSR 40-2.010 General Application Procedures

(2) Applications must be approved or denied in accordance with the timeframes established by federal and state law except when—

(A) The application is incomplete or is missing information that is necessary to complete an eligibility determination; or

(B) The division cannot reach a decision because the applicant or an examining physician delays or fails to provide the information necessary to make an eligibility determination.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services under section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013, the department adopts a rule as follows:

13 CSR 40-7.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1394–1395). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Social Services received one (1) comment.

COMMENT: The comment received indicated that the definition was lacking for non-custodial parent in that it looked to court orders if they existed, but did not take into account where parents agree to change custody of the children, but it is never formalized by modifying the court order.
RESPONSE AND EXPLANATION OF CHANGE: Language was added to the regulation in order to make it clear that court orders only control when the custody of the child is questioned. When parents agree as to which parent has physical custody of the child and there is no evidence to indicate that the person claiming to be the custodian is incorrect, the court orders will not control.

13 CSR 40-7.010 Scope and Definitions

(1) For purposes of this chapter, the following definitions shall apply:

(G) "Non-custodial parent" means the parent who does not have physical custody of the child.

1. If physical custody is questioned, a court order, judgment, decree, or any legally enforceable separation, divorce, or custody agreement establishing which party has physical custody shall control who is the custodial parent;

2. If there is no such order or agreement, or the order or agreement is silent, or in the event of joint custody, the custodial parent is the parent with whom the child expects to spend more than fifty percent (50%) of his or her overnight visits in the year for which eligibility is being determined; or

3. In the case of true joint physical custody where the child spends an equal amount of overnight visits with both parents, the non-custodial parent is the parent who does not claim the child as part of their tax household.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services under section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013, the department adopts a rule as follows:

13 CSR 40-7.015 Application Procedure for Family MO HealthNet Programs and the Children's Health Insurance Program (CHIP) **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1395–1396). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Social Services received no comments.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services under section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013, the department adopts a rule as follows:

13 CSR 40-7.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1396). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Social Services received one (1) comment.

COMMENT: The comment received indicated that the rule should make clear that a married couple who files joint taxes together should always be included in the same household, whether they live together or not.
RESPONSE AND EXPLANATION OF CHANGE: The rule has been revised to make this clear.

13 CSR 40-7.020 Household Composition

(1) A household shall include the taxpayer, or in the case of a joint return, taxpayers, and all tax dependents.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services under section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013, the department adopts a rule as follows:

13 CSR 40-7.030 Calculation of Modified Adjusted Gross Income (MAGI**) is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1396–1397). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Social Services received two (2) comments on this proposed rule.

COMMENT #1: A comment was received stating that the Modified Adjusted Gross Income methodology needed to include the five percent (5%) income disregard, which is required by federal law.
RESPONSE: This regulation details the process for calculating a participant's Modified Adjusted Gross Income, not determining the level that participant would be deemed eligible. Because the five percent (5%) disregard is applied to income levels in the determination of eligibility, and is not utilized in the calculation of a participant's Modified Adjusted Gross Income, the five percent (5%) disregard is not included in this rule.

COMMENT #2: A comment was received that indicated that the division should include specific examples of evidence that applicants can show to anticipate their future income and that the section needed to clarify that increases or decreases in family size and income can be verified by self-attestation.
RESPONSE: The rule is written in order to take into account individual participant's situations. The division believes that by listing specific examples it could be overlooking situations that could arise. The rule does not require anything specific from a participant as to verification of the anticipated changes. The division believes that the rule as drafted allows for the individual participant's situation to be taken into account.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services under section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013, the department adopts a rule as follows:

13 CSR 40-7.040 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 3, 2013 (38 MoReg 1397). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Social Services received one (1) comment.

COMMENT: A comment was received stating that the regulation is far too restrictive and places too much of the burden of documentation on the participant while ignoring the obligations of the state agency. It also states that ten (10) days is not sufficient time for information to be provided and contradicts the purposes of the Affordable Care Act which is to maintain coverage rather than terminate coverage for failure to meet burdensome paperwork requirements. It was suggested that the division use the ninety (90) days to be consistent with the exchange, but at a minimum should use sixty (60) days.

The comment goes on to say that rather than the agency setting strict timeframes that authorize the termination of coverage, the regulation should incorporate the federal provisions contained in 42 CFR 435.952.
RESPONSE AND EXPLANATION OF CHANGE: The division is bound by section 208.072, RSMo, as to applications for MO HealthNet that require an application be processed within thirty (30) days. Allowing ninety (90) days to respond to a request for documentation would force the division to be outside of the statutory times. The division did amend the rule to allow a participant to request additional time if needed when they are making a reasonable attempt to obtain the information, but is not able to obtain the information within the ten- (10-) day time period.

This regulation does incorporate the federal provisions contained in 42 CFR 435.952. Specifically, the request for documentation only is indicated if verification cannot be obtained through the electronic data hub or if the information is not reasonably compatible. Termination is only allowed under this regulation when additional information has been sought and a right to a hearing has been given.

13 CSR 40-7.040 Verification Procedures

(2) If verification cannot be obtained by the division through the electronic data hub, or if the information is not reasonably compatible

with other information provided, the division shall ask for any additional information from or on behalf of the participant needed in order to verify the information.

(A) The participant shall provide the required verification within ten (10) days from the date that the division requests the information in writing.

(B) A participant may request additional time to provide the information. The additional time shall be granted if the participant is making a reasonable effort to obtain the information.

(C) If a participant fails to provide the requested verification within ten (10) days from the date of the written request or fails to obtain additional time to provide the information, the division shall issue an adverse action notice to the participant notifying them that their coverage is denied or their coverage shall terminate ten (10) days from the date of the adverse action notice.

(D) The participant shall be given the right to request a hearing on the issue pursuant to section 208.080, RSMo. Failure on the part of the participant to request a hearing shall result in termination of coverage upon expiration of the adverse action notice.

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 15—Initiative, Referendum, New Party and Independent Candidate Petition Rules

ORDER OF RULEMAKING

By the authority vested in the Secretary of State under section 115.335.7, RSMo 2000, and section 116.130.5, RSMo Supp. 2013, the secretary adopts a rule as follows:

15 CSR 30-15.030 Initiative, Referendum, New Party and Independent Candidate Petitions Missouri Voter Registration System Option **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 16, 2013 (38 MoReg 1486–1487). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled January 21, 2014. These applications are available for public inspection at the address shown below:

Date Filed

Project Number: Project Name
City (County)
Cost, Description

12/10/13

#5000 HT: Mercy Hospital Springfield
Springfield (Greene County)
$1,940,479, Replace MRI unit

#5005 RT: Chapel Ridge Living Center
Mineral Point (Washington County)
$730,500, Replace 34-bed ALF

#5010 NT: Bethesda Dilworth
St. Louis (St. Louis County)
$2,928,000, Renovate/Modernize 400-bed SNF

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by January 9, 2014. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102

For additional information contact
Karla Houchins, (573) 751-6403.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

IN ADDITION

Pursuant to section 226.096, RSMo, regarding the Construction Claims Binding Arbitration Cap for the Missouri Department of Transportation, the Director of Insurance, Financial Institutions and Professional Registration is required to calculate the new limit.

Using Implicit Price Deflator (IPD) for Personal Consumption Expenditures (PCE), as required by section 226.096, RSMo, the Construction Claims Binding Arbitration Cap for the Missouri Department of Transportation effective January 1, 2014, was established by the following calculation:

Index Based on 2009 Dollars
Third Quarter 2012 IPD Index 106.191
Third Quarter 2013 IPD Index 107.390

New 2014 Limit = 2013 Limit × (2013 Index/2012 Index)

411,400 = 406,807 × (107.390/106.191)

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

IN ADDITION

Pursuant to section 537.610, RSMo, regarding the Sovereign Immunity Limits for Missouri Public Entities, the Director of Insurance, Financial Institutions and Professional Registration is required to calculate the new limit on awards for liability.

Using Implicit Price Deflator (IPD) for Personal Consumption Expenditures (PCE), as required by section 537.610, RSMo, the two (2) new Sovereign Immunity Limits effective January 1, 2014, were established by the following calculations:

Index Based on 2009 Dollars
Third Quarter 2012 IPD Index 106.191
Third Quarter 2013 IPD Index 107.390

New 2014 Limit = 2013 Limit × (2013 Index/2012 Index)

For all claims arising out of a single accident or occurrence:
2,687,594 = 2,657,587 × (107.390/106.191)

For any one (1) person in a single accident or occurrence:
403,139 = 398,638 × (107.390/106.191)

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

IN ADDITION

Pursuant to section 105.711, RSMo, regarding the State Legal Expense Fund, the Director of Insurance, Financial Institutions and Professional Registration is required to calculate the new limit.

Using Implicit Price Deflator (IPD) for Personal Consumption Expenditures (PCE), as required by section 105.711, RSMo, the State Legal Expense Fund Limit effective January 1, 2014, was established by the following calculation:

Index Based on 2009 Dollars
Third Quarter 2012 IPD Index 106.191
Third Quarter 2013 IPD Index 107.390

New 2014 Limit = 2013 Limit × (2013 Index/2012 Index)

420,840 = 416,141 × (107.390/106.191)

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to David E. Mollohan, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. David E Mollohan including M & D Excavating or (3) to any other simulation of Mr. David E Mollohan or of M & D Excavating for a period of one year, or until January 10, 2014.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
David E. Mollohan d/b/a M & D Excavating Case No. 11WR-CR00453 Wright County Cir. Ct.		1448 Kaylor Road Mountain Grove, MO 65711	1/10/2013	1/10/2013-1/10/2014

Dated this 28th day of January, 2013.

Robert A. Bedell, Acting Division Director

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

NOTICE OF WINDING UP AND CANCELLATION OF REGISTRATION TO ALL CREDITORS OF AND CLAIMANTS AGAINST CLAYTON LAND COMPANY L.P.

On November 25, 2013, Clayton Land Company L.P., a Missouri limited partnership (the "Partnership"), filed its Cancellation of Registration of Limited Partnership with the Missouri Secretary of State.

Pursuant to Section 359.481 of the Missouri Revised Uniform Limited Partnership Act, persons with claims against the Partnership should present them in accordance with the following procedure:

A. In order to file a claim with the Partnership, you must furnish the following: (i) name, address and phone number of claimant; (ii) date the claim was incurred; (iii) amount of the claim; (iv) brief description of the nature of the debt or the basis for the claim; and (v) supporting documentation of the claim.

B. The claim must be mailed to:

Richard A. Roloff
7350 Maryland Avenue
University City, MO 63130

A claim against the Partnership will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST GATEWAY CUSTOM SURFACES, LLC

On November 15, 2013, Gateway Custom Surfaces, LLC, a Missouri Limited Liability Company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to the Company, c/o Thomas R. Applewhite, Aektra Legal, LLC, 405 Washington Avenue, Saint Louis, MO 63102, a written summary of any claims against the Company, including: (1) the claimant's name, address and telephone number; (2) the amount of the claim or claims; (3) the date or dates the claim or claims accrued (or will accrue); (4) a brief description of the nature of the claim; and (5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against the Company will be barred unless a proceeding to enforce the claim or claims is commenced within three (3) years after the last filing or publication of this notice.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—37 (2012) and 38 (2013). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				37 MoReg 1859 38 MoReg 2053
1 CSR 10-7.010	Commissioner of Administration		38 MoReg 1738		
1 CSR 20-5.015	Personnel Advisory Board and Division of Personnel		38 MoReg 1608		
1 CSR 20-5.020	Personnel Advisory Board and Division of Personnel		38 MoReg 1608		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.020	Animal Health		38 MoReg 1360		
2 CSR 30-10.010	Animal Health		This Issue		
2 CSR 80-2.050	State Milk Board		38 MoReg 1363		
2 CSR 80-5.010	State Milk Board		38 MoReg 1363		
2 CSR 90-10	Weights and Measures				38 MoReg 1241
	DEPARTMENT OF CONSERVATION				
3 CSR 10-3.010	Conservation Commission		38 MoReg 1742		
3 CSR 10-4.130	Conservation Commission		38 MoReg 1742		
3 CSR 10-5.430	Conservation Commission		38 MoReg 1742		
3 CSR 10-6.510	Conservation Commission		38 MoReg 1742		
3 CSR 10-6.545	Conservation Commission		38 MoReg 1743		
3 CSR 10-6.550	Conservation Commission		38 MoReg 1743		
3 CSR 10-7.410	Conservation Commission		38 MoReg 1744		
3 CSR 10-7.431	Conservation Commission		38 MoReg 1744		
3 CSR 10-7.433	Conservation Commission		38 MoReg 1744		
3 CSR 10-7.440	Conservation Commission		38 MoReg 1745		
3 CSR 10-9.105	Conservation Commission		38 MoReg 1745		
3 CSR 10-9.110	Conservation Commission		38 MoReg 1747		
3 CSR 10-9.442	Conservation Commission		38 MoReg 1750		
3 CSR 10-10.705	Conservation Commission		38 MoReg 1750		
3 CSR 10-10.744	Conservation Commission		38 MoReg 1752		
3 CSR 10-11.130	Conservation Commission		38 MoReg 1752		
3 CSR 10-11.180	Conservation Commission		38 MoReg 1752		
3 CSR 10-11.184	Conservation Commission		38 MoReg 1753		
3 CSR 10-11.185	Conservation Commission		38 MoReg 1753		
3 CSR 10-11.205	Conservation Commission		38 MoReg 1754		
3 CSR 10-12.110	Conservation Commission		38 MoReg 1754		
3 CSR 10-12.115	Conservation Commission		38 MoReg 1755		
3 CSR 10-12.125	Conservation Commission		38 MoReg 1756		
3 CSR 10-12.135	Conservation Commission		38 MoReg 1756		
3 CSR 10-12.140	Conservation Commission		38 MoReg 1757		
3 CSR 10-12.145	Conservation Commission		38 MoReg 1757		
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 85-8.010	Division of Business and Community Services	38 MoReg 1925			
4 CSR 85-8.020	Division of Business and Community Services	38 MoReg 1934			
4 CSR 85-8.030	Division of Business and Community Services	38 MoReg 1934			
4 CSR 85-9.010	Division of Business and Community Services	38 MoReg 1935			
4 CSR 85-9.020	Division of Business and Community Services	38 MoReg 1936			
4 CSR 85-9.030	Division of Business and Community Services	38 MoReg 1937			
4 CSR 85-9.040	Division of Business and Community Services	38 MoReg 1947			
4 CSR 85-9.050	Division of Business and Community Services	38 MoReg 1954			
4 CSR 240-3.570	Public Service Commission		38 MoReg 1461R		
4 CSR 240-13.010	Public Service Commission		38 MoReg 1363		
4 CSR 240-13.015	Public Service Commission		38 MoReg 1364		
4 CSR 240-13.020	Public Service Commission		38 MoReg 1365		
4 CSR 240-13.025	Public Service Commission		38 MoReg 1366		
4 CSR 240-13.030	Public Service Commission		38 MoReg 1367		
4 CSR 240-13.035	Public Service Commission		38 MoReg 1368		
4 CSR 240-13.040	Public Service Commission		38 MoReg 1369		
4 CSR 240-13.045	Public Service Commission		38 MoReg 1370		
4 CSR 240-13.050	Public Service Commission		38 MoReg 1371		
4 CSR 240-13.055	Public Service Commission		38 MoReg 1375		
4 CSR 240-13.060	Public Service Commission		38 MoReg 1375		
4 CSR 240-13.070	Public Service Commission		38 MoReg 1376		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
4 CSR 240-18.010	Public Service Commission		38 MoReg 1377	This Issue	
4 CSR 240-31.010	Public Service Commission		38 MoReg 1461		
4 CSR 240-31.020	Public Service Commission		38 MoReg 1463		
4 CSR 240-31.030	Public Service Commission		38 MoReg 1464		
4 CSR 240-31.040	Public Service Commission		38 MoReg 1465R		
4 CSR 240-31.050	Public Service Commission		38 MoReg 1465R		
4 CSR 240-31.060	Public Service Commission		38 MoReg 1466		
4 CSR 240-31.065	Public Service Commission		38 MoReg 1467R		
4 CSR 240-31.070	Public Service Commission		38 MoReg 1468R		
4 CSR 240-31.080	Public Service Commission		38 MoReg 1468R		
4 CSR 240-31.090	Public Service Commission		38 MoReg 1468		
4 CSR 240-31.100	Public Service Commission		38 MoReg 1469R		
4 CSR 240-31.110	Public Service Commission		38 MoReg 1469		
4 CSR 240-31.120	Public Service Commission		38 MoReg 1470		
4 CSR 240-31.130	Public Service Commission		38 MoReg 1472		
4 CSR 240-50.050	Public Service Commission		38 MoReg 1477	This Issue	
4 CSR 240-120.065	Public Service Commission		38 MoReg 1480		
4 CSR 240-120.085	Public Service Commission		38 MoReg 1481		
4 CSR 240-120.130	Public Service Commission		38 MoReg 1481		
4 CSR 240-123.065	Public Service Commission		38 MoReg 1482		
4 CSR 240-123.070	Public Service Commission		38 MoReg 1483		
4 CSR 240-123.095	Public Service Commission		38 MoReg 1483		
4 CSR 240-125.010	Public Service Commission		38 MoReg 1484		
4 CSR 240-125.040	Public Service Commission		38 MoReg 1484		
4 CSR 240-125.070	Public Service Commission		38 MoReg 1485		
4 CSR 265-2.068	Division of Motor Carrier and Railroad Safety *(Changed to 7 CSR 265-10.035)*		38 MoReg 887	38 MoReg 1892	
4 CSR 265-2.180	Division of Motor Carrier and Railroad Safety *(Changed to 7 CSR 265-10.140)*		38 MoReg 896	38 MoReg 1894	
4 CSR 265-2.190	Division of Motor Carrier and Railroad Safety *(Changed to 7 CSR 265-10.090)*		38 MoReg 894	38 MoReg 1893	
4 CSR 265-6.010	Division of Motor Carrier and Railroad Safety *(Changed to 7 CSR 265-10.055)*		38 MoReg 892	38 MoReg 1892	
4 CSR 265-12.020	Division of Motor Carrier and Railroad Safety		38 MoReg 881R	38 MoReg 1890R	
4 CSR 265-12.030	Division of Motor Carrier and Railroad Safety		38 MoReg 882R	38 MoReg 1890R	
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 10-1.010	Commissioner of Education		38 MoReg 1527		
5 CSR 10-2.010	Commissioner of Education		38 MoReg 1966		
5 CSR 10-2.020	Commissioner of Education		38 MoReg 1971		
5 CSR 10-2.030	Commissioner of Education		38 MoReg 1971		
5 CSR 20-100.170	Division of Learning Services		38 MoReg 1972R		
5 CSR 20-100.255	Division of Learning Services		37 MoReg 1571	38 MoReg 520F	
5 CSR 20-100.265	Division of Learning Services		38 MoReg 1758		
5 CSR 20-200.290	Division of Learning Services		38 MoReg 1762		
5 CSR 20-200.300	Division of Learning Services		38 MoReg 1762		
5 CSR 20-300.160	Division of Learning Services		38 MoReg 1527		
5 CSR 20-300.170	Division of Learning Services		38 MoReg 1528		
5 CSR 20-300.180	Division of Learning Services		38 MoReg 1531		
5 CSR 20-300.190	Division of Learning Services		38 MoReg 1531		
5 CSR 20-300.200	Division of Learning Services		38 MoReg 1531		
5 CSR 20-400.375	Division of Learning Services		38 MoReg 825 38 MoReg 1972		
5 CSR 20-400.500	Division of Learning Services		38 MoReg 1976		
5 CSR 20-400.510	Division of Learning Services		38 MoReg 1977		
5 CSR 20-400.520	Division of Learning Services		38 MoReg 1978		
5 CSR 20-400.530	Division of Learning Services		38 MoReg 1979		
5 CSR 20-400.540	Division of Learning Services		38 MoReg 1981		
5 CSR 20-400.550	Division of Learning Services		38 MoReg 1985		
5 CSR 20-400.560	Division of Learning Services		38 MoReg 1987		
5 CSR 20-400.570	Division of Learning Services		38 MoReg 1992		
5 CSR 20-400.580	Division of Learning Services		38 MoReg 1992		
5 CSR 20-400.590	Division of Learning Services		38 MoReg 1993		
5 CSR 20-400.600	Division of Learning Services		38 MoReg 1994		
5 CSR 20-400.610	Division of Learning Services		38 MoReg 1994		
5 CSR 20-400.620	Division of Learning Services		38 MoReg 1998		
5 CSR 20-400.630	Division of Learning Services		38 MoReg 1998		
5 CSR 20-400.640	Division of Learning Services		38 MoReg 1999		
5 CSR 20-400.650	Division of Learning Services		38 MoReg 2002		
5 CSR 20-400.660	Division of Learning Services		38 MoReg 2003		
5 CSR 20-400.670	Division of Learning Services		38 MoReg 2005		
5 CSR 20-400.680	Division of Learning Services		38 MoReg 2006		
5 CSR 20-400.690	Division of Learning Services		38 MoReg 2007		
5 CSR 20-400.700	Division of Learning Services		38 MoReg 2008		
5 CSR 20-500.120	Division of Learning Services		38 MoReg 1764		
5 CSR 30-640.100	Division of Financial and Administrative Services		38 MoReg 1532R		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-6.010	Missouri Highways and Transportation Commission		38 MoReg 1860		
7 CSR 10-6.015	Missouri Highways and Transportation Commission		38 MoReg 1861		
7 CSR 10-6.020	Missouri Highways and Transportation Commission		38 MoReg 1862		
7 CSR 10-6.030	Missouri Highways and Transportation Commission		38 MoReg 1863		
7 CSR 10-6.040	Missouri Highways and Transportation Commission		38 MoReg 1864		
7 CSR 10-6.050	Missouri Highways and Transportation Commission		38 MoReg 1870		
7 CSR 10-6.060	Missouri Highways and Transportation Commission		38 MoReg 1870		
7 CSR 10-6.070	Missouri Highways and Transportation Commission		38 MoReg 1871		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
7 CSR 10-6.080	Missouri Highways and Transportation Commission		38 MoReg 1873		
7 CSR 10-6.085	Missouri Highways and Transportation Commission		38 MoReg 1874		
7 CSR 10-6.090	Missouri Highways and Transportation Commission		38 MoReg 1876		
7 CSR 60-2.010	Traffic and Highway Safety Division	38 MoReg 1591	38 MoReg 1610		
7 CSR 60-2.020	Traffic and Highway Safety Division	38 MoReg 1593	38 MoReg 1611		
7 CSR 60-2.030	Traffic and Highway Safety Division	38 MoReg 1595	38 MoReg 1612		
7 CSR 60-2.040	Traffic and Highway Safety Division	38 MoReg 1597	38 MoReg 1613		
7 CSR 60-2.050	Traffic and Highway Safety Division	38 MoReg 1600	38 MoReg 1615		
7 CSR 60-2.060	Traffic and Highway Safety Division		38 MoReg 1616		
7 CSR 265-10.010	Motor Carrier and Railroad Safety		38 MoReg 882	38 MoReg 1890	
7 CSR 265-10.015	Motor Carrier and Railroad Safety		38 MoReg 883R 38 MoReg 883	38 MoReg 1890R 38 MoReg 1891	
7 CSR 265-10.020	Motor Carrier and Railroad Safety		38 MoReg 884R 38 MoReg 884	38 MoReg 1891R 38 MoReg 1891	
7 CSR 265-10.025	Motor Carrier and Railroad Safety		38 MoReg 885R 38 MoReg 885	38 MoReg 1891R 38 MoReg 1891	
7 CSR 265-10.030	Motor Carrier and Railroad Safety		38 MoReg 886R 38 MoReg 886	38 MoReg 1891R 38 MoReg 1892	
7 CSR 265-10.035	Motor Carrier and Railroad Safety *(Changed from 4 CSR 265-2.068)*		38 MoReg 887	38 MoReg 1892	
7 CSR 265-10.040	Motor Carrier and Railroad Safety		38 MoReg 888R 38 MoReg 888	38 MoReg 1892R 38 MoReg 1892	
7 CSR 265-10.045	Motor Carrier and Railroad Safety		38 MoReg 889	38 MoReg 1892	
7 CSR 265-10.050	Motor Carrier and Railroad Safety		38 MoReg 889	38 MoReg 1892	
7 CSR 265-10.055	Motor Carrier and Railroad Safety *(Changed from 4 CSR 265-6.010)*		38 MoReg 892	38 MoReg 1892	
7 CSR 265-10.060	Motor Carrier and Railroad Safety		38 MoReg 893R	38 MoReg 1893R	
7 CSR 265-10.070	Motor Carrier and Railroad Safety		38 MoReg 893R	38 MoReg 1893R	
7 CSR 265-10.080	Motor Carrier and Railroad Safety		38 MoReg 893R	38 MoReg 1893R	
7 CSR 265-10.090	Motor Carrier and Railroad Safety *(Changed from 4 CSR 265-2.190)*		38 MoReg 894	38 MoReg 1893	
7 CSR 265-10.100	Motor Carrier and Railroad Safety		38 MoReg 894	38 MoReg 1893	
7 CSR 265-10.110	Motor Carrier and Railroad Safety		38 MoReg 895R 38 MoReg 895	38 MoReg 1893R 38 MoReg 1894	
7 CSR 265-10.120	Motor Carrier and Railroad Safety		38 MoReg 896R	38 MoReg 1894R	
7 CSR 265-10.130	Motor Carrier and Railroad Safety		38 MoReg 896	38 MoReg 1894	
7 CSR 265-10.140	Motor Carrier and Railroad Safety *(Changed from 4 CSR 265-2.180)*		38 MoReg 896	38 MoReg 1894	
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 10-3.085	Division of Employment Security		38 MoReg 1876		
8 CSR 10-3.150	Division of Employment Security	38 MoReg 1515	38 MoReg 1532		
8 CSR 10-4.020	Division of Employment Security		38 MoReg 1533		
8 CSR 10-4.210	Division of Employment Security	38 MoReg 1516	38 MoReg 1533		
8 CSR 50-2.030	Division of Workers' Compensation		38 MoReg 2087		
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-3.010	Air Conservation Commission		38 MoReg 1100R	38 MoReg 2045R	
10 CSR 10-5.240	Air Conservation Commission		38 MoReg 1877R		
10 CSR 10-6.010	Air Conservation Commission		38 MoReg 2089		
10 CSR 10-6.020	Air Conservation Commission		38 MoReg 1265		
10 CSR 10-6.070	Air Conservation Commission		38 MoReg 898	38 MoReg 1827	
10 CSR 10-6.075	Air Conservation Commission		38 MoReg 899	38 MoReg 1827	
10 CSR 10-6.080	Air Conservation Commission		38 MoReg 902	38 MoReg 1827	
10 CSR 10-6.130	Air Conservation Commission		38 MoReg 903	38 MoReg 1827	
10 CSR 10-6.161	Air Conservation Commission		38 MoReg 1297		
10 CSR 10-6.200	Air Conservation Commission		38 MoReg 1382 38 MoReg 2008		
10 CSR 20-6.011	Clean Water Commission		38 MoReg 1534		
10 CSR 20-7.015	Clean Water Commission		38 MoReg 913		
10 CSR 20-7.031	Clean Water Commission		38 MoReg 939		
10 CSR 23-5.010	Division of Geology and Land Survey		38 MoReg 1101	38 MoReg 1894	
10 CSR 23-5.020	Division of Geology and Land Survey		38 MoReg 1101	38 MoReg 1895	
10 CSR 23-5.030	Division of Geology and Land Survey		38 MoReg 1102	38 MoReg 1895	
10 CSR 23-5.040	Division of Geology and Land Survey		38 MoReg 1102	38 MoReg 1895	
10 CSR 23-5.050	Division of Geology and Land Survey		38 MoReg 1103	38 MoReg 1895	
10 CSR 23-5.060	Division of Geology and Land Survey		38 MoReg 1105	38 MoReg 1898	
10 CSR 23-5.070	Division of Geology and Land Survey		38 MoReg 1105	38 MoReg 1898	
10 CSR 23-5.080	Division of Geology and Land Survey		38 MoReg 1106	38 MoReg 1898	
10 CSR 26-2.062	Petroleum and Hazardous Substance Storage Tanks		38 MoReg 1160	This Issue	
10 CSR 26-2.078	Petroleum and Hazardous Substance Storage Tanks		38 MoReg 1161	This Issue	
10 CSR 26-2.082	Petroleum and Hazardous Substance Storage Tanks		38 MoReg 1162	This Issue	
10 CSR 40-6.030	Land Reclamation Commission		38 MoReg 1298	38 MoReg 2045	
10 CSR 40-6.070	Land Reclamation Commission		38 MoReg 1299	38 MoReg 2045	
10 CSR 40-6.100	Land Reclamation Commission		38 MoReg 1300	38 MoReg 2045	
10 CSR 40-8.030	Land Reclamation Commission		38 MoReg 1301	38 MoReg 2046	
10 CSR 40-8.040	Land Reclamation Commission		38 MoReg 1301	38 MoReg 2046	
10 CSR 140-2	Division of Energy				38 MoReg 432 38 MoReg 1431

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 30-14.010	Office of the Director	38 MoReg 243	38 MoReg 249 38 MoReg 1486	This Issue	
11 CSR 30-15.010	Office of the Director	38 MoReg 1351	38 MoReg 1391	This Issue	
11 CSR 45-5.237	Missouri Gaming Commission		38 MoReg 2019		
11 CSR 45-9.106	Missouri Gaming Commission		38 MoReg 828	38 MoReg 1828	
11 CSR 45-9.110	Missouri Gaming Commission		38 MoReg 828	38 MoReg 1829	
11 CSR 45-9.111	Missouri Gaming Commission		38 MoReg 2020		
11 CSR 45-9.118	Missouri Gaming Commission		38 MoReg 828	38 MoReg 1832	
11 CSR 45-9.119	Missouri Gaming Commission		38 MoReg 2022		
11 CSR 75-17.010	Peace Officer Standards and Training Program	38 MoReg 1517	38 MoReg 1549	This Issue	
11 CSR 75-17.020	Peace Officer Standards and Training Program	38 MoReg 1518	38 MoReg 1549	This Issue	
11 CSR 75-17.030	Peace Officer Standards and Training Program	38 MoReg 1518	38 MoReg 1549	This Issue	
11 CSR 75-17.040	Peace Officer Standards and Training Program	38 MoReg 1519	38 MoReg 1550	This Issue	
11 CSR 85-1.010	Veterans Affairs		38 MoReg 1163	38 MoReg 1832	
11 CSR 85-1.015	Veterans Affairs		38 MoReg 1163	38 MoReg 1832	
11 CSR 85-1.020	Veterans Affairs		38 MoReg 1164	38 MoReg 1832	
11 CSR 85-1.030	Veterans Affairs		38 MoReg 1164	38 MoReg 1833	
11 CSR 85-1.040	Veterans Affairs		38 MoReg 1165	38 MoReg 1833	
11 CSR 85-1.050	Veterans Affairs		38 MoReg 1165	38 MoReg 1833	
	DEPARTMENT OF REVENUE				
12 CSR 10-2.052	Director of Revenue		38 MoReg 1764		
12 CSR 10-23.500	Director of Revenue	38 MoReg 1520	38 MoReg 1550	This Issue	
12 CSR 10-41.010	Director of Revenue	38 MoReg 1965	38 MoReg 2022		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 35-36.010	Children's Division		38 MoReg 2025		
13 CSR 40-2.010	Family Support Division		38 MoReg 1393	This Issue	
13 CSR 40-7.010	Family Support Division		38 MoReg 1394	This Issue	
13 CSR 40-7.015	Family Support Division		38 MoReg 1395	This Issue	
13 CSR 40-7.020	Family Support Division		38 MoReg 1396	This Issue	
13 CSR 40-7.030	Family Support Division		38 MoReg 1396	This Issue	
13 CSR 40-7.040	Family Support Division		38 MoReg 1397	This Issue	
13 CSR 40-24.080	Family Support Division		38 MoReg 2026		
13 CSR 40-24.090	Family Support Division		38 MoReg 2032		
13 CSR 40-24.100	Family Support Division		38 MoReg 2035		
13 CSR 40-100.040	Family Support Division	38 MoReg 1601	38 MoReg 1617		
13 CSR 70-3.030	MO Heathcote Division		38 MoReg 1617		
13 CSR 70-3.200	MO HealthNet Division		38 MoReg 1877		
13 CSR 70-4.120	MO HealthNet Division		38 MoReg 1765		
13 CSR 70-10.015	MO HealthNet Division		38 MoReg 1218	38 MoReg 2046	
13 CSR 70-10.016	MO HealthNet Division		38 MoReg 2039		
13 CSR 70-10.160	MO HealthNet Division	38 MoReg 1520	38 MoReg 1221	38 MoReg 2046	
13 CSR 70-15.010	MO HealthNet Division	38 MoReg 1215	38 MoReg 1222	38 MoReg 2046	
13 CSR 70-15.030	MO HealthNet Division		38 MoReg 1618		
13 CSR 70-15.110	MO HealthNet Division	38 MoReg 1216	38 MoReg 1226	38 MoReg 2046	
13 CSR 70-15.160	MO HealthNet Division		38 MoReg 1232	38 MoReg 2047	
13 CSR 70-20.031	MO HealthNet Division		38 MoReg 1619		
13 CSR 70-20.032	MO HealthNet Division		38 MoReg 1620		
13 CSR 70-20.050	MO HealthNet Division		38 MoReg 1620		
13 CSR 70-20.060	MO HealthNet Division		38 MoReg 1768		
13 CSR 70-20.071	MO HealthNet Division		38 MoReg 1769		
13 CSR 70-20.200	MO HealthNet Division		38 MoReg 1769		
13 CSR 70-20.250	MO HealthNet Division		38 MoReg 1621		
13 CSR 70-20.300	MO HealthNet Division		38 MoReg 1621		
13 CSR 70-20.310	MO HealthNet Division		38 MoReg 1622		
13 CSR 70-25.120	MO HealthNet Division		38 MoReg 1880		
13 CSR 70-40.010	MO HealthNet Division		38 MoReg 1882		
13 CSR 70-45.010	MO HealthNet Division		38 MoReg 1883		
13 CSR 70-50.010	MO HealthNet Division		38 MoReg 1770		
13 CSR 70-60.010	MO HealthNet Division		38 MoReg 1776		
13 CSR 70-70.010	MO HealthNet Division		38 MoReg 1776		
13 CSR 70-98.015	MO HealthNet Division		38 MoReg 1777		
13 CSR 70-98.020	MO HealthNet Division		38 MoReg 1884		
	DEPARTMENT OF CORRECTIONS				
14 CSR 80-5.010	State Board of Probation and Parole		38 MoReg 2043		
14 CSR 80-5.020	State Board of Probation and Parole		38 MoReg 2043		
	ELECTED OFFICIALS				
15 CSR 30-15.010	Secretary of State		38 MoReg 1553		
15 CSR 30-15.020	Secretary of State		38 MoReg 1553		
15 CSR 30-15.030	Secretary of State		38 MoReg 1486	This Issue	
15 CSR 30-50.010	Secretary of State		38 MoReg 835		
15 CSR 30-50.040	Secretary of State		38 MoReg 835		
15 CSR 30-52.015	Secretary of State		38 MoReg 836		
15 CSR 30-52.030	Secretary of State		38 MoReg 836		
15 CSR 30-52.275	Secretary of State		38 MoReg 837		
15 CSR 30-54.010	Secretary of State		38 MoReg 837		
15 CSR 30-54.070	Secretary of State		38 MoReg 837		
15 CSR 30-54.150	Secretary of State		38 MoReg 838		
15 CSR 30-90.010	Secretary of State	38 MoReg 1522	38 MoReg 1554		
15 CSR 30-90.090	Secretary of State	38 MoReg 1522	38 MoReg 1554		
15 CSR 30-90.170	Secretary of State	38 MoReg 1523	38 MoReg 1555		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	RETIREMENT SYSTEMS				
16 CSR 10-1.040	The Public School Retirement System of Missouri		38 MoReg 1232	38 MoReg 2047	
16 CSR 10-3.010	The Public School Retirement System of Missouri		38 MoReg 1233	38 MoReg 2047	
16 CSR 10-4.005	The Public School Retirement System of Missouri		38 MoReg 1234	38 MoReg 2047	
16 CSR 10-5.010	The Public School Retirement System of Missouri		38 MoReg 1235	38 MoReg 2047	
16 CSR 10-6.020	The Public School Retirement System of Missouri		38 MoReg 1235	38 MoReg 2048	
16 CSR 10-6.060	The Public School Retirement System of Missouri		38 MoReg 1237	38 MoReg 2048	
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 25-30.031	State Public Health Laboratory	38 MoReg 1602	38 MoReg 1623		
19 CSR 25-30.050	State Public Health Laboratory	38 MoReg 1604	38 MoReg 1625		
19 CSR 25-30.051	State Public Health Laboratory		38 MoReg 1625		
19 CSR 25-30.060	State Public Health Laboratory	38 MoReg 1604	38 MoReg 1626		
19 CSR 30-20.098	Division of Regulation and Licensure		38 MoReg 1166	38 MoReg 2093	
19 CSR 30-20.110	Division of Regulation and Licensure		38 MoReg 1167	38 MoReg 2093	
19 CSR 30-20.112	Division of Regulation and Licensure		38 MoReg 1168	38 MoReg 2093	
19 CSR 30-20.114	Division of Regulation and Licensure		38 MoReg 1168	38 MoReg 2094	
19 CSR 30-20.118	Division of Regulation and Licensure		38 MoReg 1170	38 MoReg 2094	
19 CSR 30-20.122	Division of Regulation and Licensure		38 MoReg 1170R	38 MoReg 2094R	
19 CSR 30-20.124	Division of Regulation and Licensure		38 MoReg 1171	38 MoReg 2094	
19 CSR 30-20.142	Division of Regulation and Licensure		38 MoReg 1171	38 MoReg 2095	
19 CSR 60-50	Missouri Health Facilties Review Committee				38 MoReg 1834 38 MoReg 2056 This Issue
	DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION				
20 CSR	Applied Behavior Analysis Maximum Benefit				38 MoReg 432
20 CSR	Construction Claims Binding Arbitration Cap				38 MoReg 147 This Issue
20 CSR	Sovereign Immunity Limits				38 MoReg 147 This Issue
20 CSR	State Legal Expense Fund Cap				38 MoReg 147 This Issue
20 CSR 200-2.100	Insurance Solvency and Company Regulation	38 MoReg 1695	38 MoReg 1778		
20 CSR 400-2.160	Life, Annuities and Health		38 MoReg 1555		
20 CSR 400-5.600	Life, Annuities and Health		38 MoReg 1885		
20 CSR 400-11.100	Life, Annuities and Health	38 MoReg 1353	38 MoReg 1397	38 MoReg 2095	
20 CSR 400-11.120	Life, Annuities and Health	38 MoReg 1732	38 MoReg 1816		
20 CSR 400-12.100	Life, Annuities and Health	38 MoReg 1737	38 MoReg 1826		
20 CSR 1140-30.240	Division of Finance		38 MoReg 1628		
20 CSR 2010-2.160	Missouri State Board of Accountancy	38 MoReg 1159	38 MoReg 1172	38 MoReg 1833	
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		38 MoReg 1487		
20 CSR 2030-2.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		38 MoReg 1487		
20 CSR 2030-2.060	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		38 MoReg 1487		
20 CSR 2063-6.005	Behavior Analyst Advisory Board		38 MoReg 1631		
20 CSR 2085-8.070	Board of Cosmetology and Barber Examiners		This Issue		
20 CSR 2085-12.010	Board of Cosmetology and Barber Examiners		38 MoReg 1637		
20 CSR 2085-12.020	Board of Cosmetology and Barber Examiners		38 MoReg 1637		
20 CSR 2085-13.070	Board of Cosmetology and Barber Examiners		38 MoReg 1638		
20 CSR 2145-1.040	Missouri Board of Geologist Registration		38 MoReg 1114	38 MoReg 2048	
20 CSR 2145-2.020	Missouri Board of Geologist Registration		38 MoReg 1116	38 MoReg 2048	
20 CSR 2145-2.030	Missouri Board of Geologist Registration		38 MoReg 1116	38 MoReg 2048	
20 CSR 2145-2.065	Missouri Board of Geologist Registration		38 MoReg 1117	38 MoReg 2049	
20 CSR 2145-2.080	Missouri Board of Geologist Registration		38 MoReg 1120	38 MoReg 2049	
20 CSR 2165-1.020	Board of Examiners for Hearing Instrument Specialists		38 MoReg 1638		
20 CSR 2165-2.030	Board of Examiners for Hearing Instrument Specialists		38 MoReg 1641		
20 CSR 2200-1.010	State Board of Nursing		38 MoReg 1641		
20 CSR 2200-4.020	State Board of Nursing		38 MoReg 1642		
20 CSR 2200-4.030	State Board of Nursing		38 MoReg 1556		
20 CSR 2205-3.030	Missouri Board of Occupational Therapy		38 MoReg 1303	38 MoReg 2049	
20 CSR 2210-2.030	State Board of Optometry		This Issue		
20 CSR 2220-2.950	State Board of Pharmacy		38 MoReg 1237	38 MoReg 2049	
20 CSR 2231-2.010	Division of Professional Registration		38 MoReg 1643		
20 CSR 2232-1.040	Missouri State Committee of Interpreters		38 MoReg 1409	38 MoReg 2095	
20 CSR 2232-2.010	Missouri State Committee of Interpreters		38 MoReg 1412	38 MoReg 2096	
20 CSR 2232-2.020	Missouri State Committee of Interpreters		38 MoReg 1416	38 MoReg 2096	
20 CSR 2232-2.030	Missouri State Committee of Interpreters		38 MoReg 1420	38 MoReg 2096	
20 CSR 2234-1.010	Board of Private Investigator Examiners		38 MoReg 1643		
20 CSR 2234-1.020	Board of Private Investigator Examiners		38 MoReg 1643		
20 CSR 2234-1.030	Board of Private Investigator Examiners		38 MoReg 1644		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2234-1.040	Board of Private Investigator Examiners		38 MoReg 1644		
20 CSR 2234-1.050	Board of Private Investigator Examiners		38 MoReg 1645		
20 CSR 2234-2.010	Board of Private Investigator Examiners		38 MoReg 1649		
20 CSR 2234-2.015	Board of Private Investigator Examiners		38 MoReg 1649		
20 CSR 2234-2.020	Board of Private Investigator Examiners		38 MoReg 1654		
20 CSR 2234-2.030	Board of Private Investigator Examiners		38 MoReg 1654		
20 CSR 2234-2.040	Board of Private Investigator Examiners		38 MoReg 1654		
20 CSR 2234-3.010	Board of Private Investigator Examiners		38 MoReg 1658		
20 CSR 2234-3.020	Board of Private Investigator Examiners		38 MoReg 1658		
20 CSR 2234-3.030	Board of Private Investigator Examiners		38 MoReg 1659		
20 CSR 2234-3.040	Board of Private Investigator Examiners		38 MoReg 1659		
20 CSR 2234-3.070	Board of Private Investigator Examiners		38 MoReg 1659		
20 CSR 2234-4.010	Board of Private Investigator Examiners		38 MoReg 1660R		
20 CSR 2234-4.020	Board of Private Investigator Examiners		38 MoReg 1660R		
20 CSR 2234-4.030	Board of Private Investigator Examiners		38 MoReg 1660R		
20 CSR 2234-4.040	Board of Private Investigator Examiners		38 MoReg 1660R		
20 CSR 2234-4.050	Board of Private Investigator Examiners		38 MoReg 1661R		
20 CSR 2234-6.010	Board of Private Investigator Examiners		38 MoReg 1661		
20 CSR 2234-7.010	Board of Private Investigator Examiners		38 MoReg 1665		
20 CSR 2235-1.020	State Committee of Psychologists		38 MoReg 1175	38 MoReg 2050	
20 CSR 2235-1.025	State Committee of Psychologists		38 MoReg 1179	38 MoReg 2050	
20 CSR 2235-1.026	State Committee of Psychologists		38 MoReg 1179	38 MoReg 2050	
20 CSR 2235-1.030	State Committee of Psychologists		38 MoReg 1179R 38 MoReg 1180	38 MoReg 2051R 38 MoReg 2051	
20 CSR 2235-2.060	State Committee of Psychologists		38 MoReg 1182	38 MoReg 2051	
20 CSR 2235-2.065	State Committee of Psychologists		38 MoReg 1182	38 MoReg 2051	
20 CSR 2245-1.010	Real Estate Appraisers		38 MoReg 1303	38 MoReg 2052	
20 CSR 2245-3.005	Real Estate Appraisers		38 MoReg 1304	38 MoReg 2052	
20 CSR 2245-3.010	Real Estate Appraisers		38 MoReg 1304	38 MoReg 2052	
20 CSR 2245-6.040	Real Estate Appraisers		38 MoReg 1305	38 MoReg 2052	
20 CSR 2245-8.010	Real Estate Appraisers		38 MoReg 1305	38 MoReg 2052	
20 CSR 2245-8.030	Real Estate Appraisers		38 MoReg 1306	38 MoReg 2052	
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-1.010	Health Care Plan		This Issue		
22 CSR 10-1.020	Health Care Plan		This Issue		
22 CSR 10-2.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.030	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.051	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.052	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.054	Health Care Plan	This IssueR	This IssueR		
22 CSR 10-2.055	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.060	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.070	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.089	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.090	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.094	Health Care Plan	38 MoReg 1524	38 MoReg 1557		
22 CSR 10-2.110	Health Care Plan		This Issue		
22 CSR 10-2.120	Health Care Plan	38 MoReg 1525	38 MoReg 1559		
22 CSR 10-2.130	Health Care Plan	38 MoReg 1359R	38 MoReg 1420R	38 MoReg 2096R	
22 CSR 10-2.140	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.054	Health Care Plan	This IssueR	This IssueR		
22 CSR 10-3.055	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.056	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.057	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-3.060	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.090	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.130	Health Care Plan	38 MoReg 1359R	38 MoReg 1423R	38 MoReg 2096R	

Agency		Publication	Effective	Expiration
Department of Economic Development				
Division of Business and Community Services				
4 CSR 85-8.010	Definitions	38 MoReg 1925	Nov. 7, 2013	May 5, 2014
4 CSR 85-8.020	Program Administration	38 MoReg 1934	Nov. 7, 2013	May 5, 2014
4 CSR 85-8.030	Tax Credit Accountability Act Compliance	38 MoReg 1934	Nov. 7, 2013	May 5, 2014
4 CSR 85-9.010	Definitions	38 MoReg 1935	Nov. 7, 2013	May 5, 2014
4 CSR 85-9.020	Application Process	38 MoReg 1936	Nov. 7, 2013	May 5, 2014
4 CSR 85-9.030	Project Proposal	38 MoReg 1937	Nov. 7, 2013	May 5, 2014
4 CSR 85-9.040	Event Notification	38 MoReg 1947	Nov. 7, 2013	May 5, 2014
4 CSR 85-9.050	Final Application	38 MoReg 1954	Nov. 7, 2013	May 5, 2014
Department of Transportation				
Traffic and Highway Safety Division				
7 CSR 60-2.010	Definitions	38 MoReg 1591	Oct. 1, 2013	March 29, 2014
7 CSR 60-2.020	Approval Procedure	38 MoReg 1593	Oct. 1, 2013	March 29, 2014
7 CSR 60-2.030	Standards and Specifications	38 MoReg 1595	Oct. 1, 2013	March 29, 2014
7 CSR 60-2.040	Responsibilities of Authorized Service Providers	38 MoReg 1597	Oct. 1, 2013	March 29, 2014
7 CSR 60-2.050	Breath Alcohol Ignition Interlock Devise Security	38 MoReg 1600	Oct. 1, 2013	March 29, 2014
Department of Labor and Industrial Relations				
Division of Employment Security				
8 CSR 10-3.150	Fraud Penalties on Federal and State Benefits	38 MoReg 1515	Oct. 1, 2013	March 29, 2014
8 CSR 10-4.210	Prohibition on the Non-Charging Benefits	38 MoReg 1516	Oct. 1, 2013	March 29, 2014
Department of Public Safety				
Office of the Director				
11 CSR 30-15.010	Format for Concealed Carry Permits	38 MoReg 1351	Aug. 28, 2013	Feb. 27, 2014
Peace Officer Standards and Training Program				
11 CSR 75-17.010	Minimum Training Standards for School Protection Officer Training Centers	38 MoReg 1517	Sept. 2, 2013	Feb. 28, 2014
11 CSR 75-17.020	Minimum Training Standards for School Protection Officer Training Instructors	38 MoReg 1518	Sept. 2, 2013	Feb. 28, 2014
11 CSR 75-17.030	Minimum Training Standards for School Protection Officers	38 MoReg 1518	Sept. 2, 2013	Feb. 28, 2014
11 CSR 75-17.040	Minimum Continuing Education Training Standards for School Protection Officers	38 MoReg 1519	Sept. 2, 2013	Feb. 28, 2014
Department of Revenue				
Director of Revenue				
12 CSR 10-23.500	Optional Second Plate for Commercial Motor Vehicles	38 MoReg 1520	Aug. 29, 2013	Feb. 27, 2014
12 CSR 10-41.010	Annual Adjusted Rate of Interest	38 MoReg 1965	Jan. 1, 2014	June 29, 2014
Department of Social Services				
Family Support Division				
13 CSR 40-100.040	State Directory of New Hires	38 MoReg 1601	Sept. 26, 2013	March 24, 2014
MO HealthNet Division				
13 CSR 70-10.160	Public/Private Long-Term Care Services and Supports Partnership Supplemental Payment to Nursing Facilities	38 MoReg 1520	Sept. 7, 2013	March 5, 2014
Elected Officials				
Secretary of State				
15 CSR 30-90.010	Definitions	38 MoReg 1522	Aug. 28, 2013	Feb. 27, 2014
15 CSR 30-90.090	Refusal to File; Cancellation; Defects in Filing	38 MoReg 1522	Aug. 28, 2013	Feb. 27, 2014
15 CSR 30-90.170	Status of Parties upon Filing an Information Statement	38 MoReg 1523	Aug. 28, 2013	Feb. 27, 2014
Department of Health and Senior Services				
State Public Health Laboratory				
19 CSR 25-30.031	Type II Permits	38 MoReg 1602	Sept. 15, 2013	March 13, 2014
19 CSR 25-30.050	Approved Breath Analyzers	38 MoReg 1604	Sept. 15, 2013	March 13, 2014

Agency		Publication	Effective	Expiration
19 CSR 25-30.060	Operating Procedures for Breath Analyzers	38 MoReg 1604	Sept. 15, 2013	March 13, 2014
Department of Insurance, Financial Institutions and Professional Registration				
Financial Examination				
20 CSR 200-2.100	Credit for Reinsurance	38 MoReg 1695	Jan. 1, 2014	June 29, 2014
Life, Annuities and Health				
20 CSR 400-11.100	Navigator Examination and Licensing Procedures and Standards	38 MoReg 1353	Aug. 3, 2013	Jan. 29, 2014
20 CSR 400-11.120	Continuing Education for Individual Navigators	38 MoReg 1732	Sept. 30, 2013	March 28, 2014
20 CSR 400-12.100	Missouri Health Insurance Pool Transitional Plan of Operation	38 MoReg 1737	Sept. 30, 2013	March 28, 2014
Missouri State Board of Accountancy				
20 CSR 2010-2.160	Fees	38 MoReg 1159	June 28, 2013	Feb. 27, 2014
Acupuncturist Advisory Committee				
20 CSR 2015-1.030	Fees	38 MoReg 751	April 18, 2013	Jan. 28, 2014
Committee for Professional Counselors				
20 CSR 2095-1.020	Fees	38 MoReg 751	April 18, 2013	Jan. 28, 2014
Missouri Consolidated Health Care Plan				
Health Care Plan				
22 CSR 10-2.010	Definitions	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.020	General Membership Provisions	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.030	Contributions	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.045	Plan Utilization Review Policy	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.053	High Deductible Health Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.054	Medicare Supplement Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.060	PPO 300 Plan, PPO 600 Plan, and HDHP Limitations	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.070	Coordination of Benefits	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.075	Review and Appeals Procedure	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.090	Pharmacy Benefit Summary	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-2.094	Tobacco-Free Incentive Provisions and Limitations	38 MoReg 1524	Oct. 1, 2013	March 29, 2014
22 CSR 10-2.120	Wellness Program	38 MoReg 1525	Oct. 1, 2013	March 29, 2014
22 CSR 10-2.130	Additional Plan Options	38 MoReg 1359	July 26, 2013	Jan. 21, 2014
22 CSR 10-2.140	Wellness Center Provisions, Charges, and Services	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.010	Definitions	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.020	General Membership Provisions	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.045	Plan Utilization Review Policy	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.054	PPO 2000 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.055	High Deductible Health Plan Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.056	PPO 600 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.060	PPO 600, PPO 1000 Plan, and HDHP Limitations	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.075	Review and Appeals Procedure	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.090	Pharmacy Benefit Summary	This Issue	Jan. 1, 2014	June 29, 2014
22 CSR 10-3.130	Additional Plan Options	38 MoReg 1359	July 26, 2013	Jan. 21, 2014

Executive Orders	Subject Matter	Filed Date	Publication
	2013		
13-14	Orders the Missouri Department of Revenue to follow sections 143.031.1 and 143.091, RSMo, and require all taxpayers who properly file a joint federal income tax return to file a combined state income tax return.	Nov. 14, 2013	38 MoReg 2085
13-13	Advises that state offices will be closed on Friday November 29, 2013.	Nov. 1, 2013	38 MoReg 1859
13-12	Activates the state militia in response to the heavy rains, flooding, and flash flooding that began on Aug. 2, 2013.	Aug. 7, 2013	38 MoReg 1459
13-11	Declares a state of emergency and activates the Missouri State Operation Plan due to heavy rains, flooding, and flash flooding.	Aug. 6, 2013	38 MoReg 1457
13-10	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	May 31, 2013	38 MoReg 1097
13-09	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies.	May 3, 2013	38 MoReg 879
13-08	Activates the state militia in response to severe weather that began on April 16, 2013.	April 19, 2013	38 MoReg 823
13-07	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to severe weather that began on April 16, 2013.	April 19, 2013	38 MoReg 821
13-06	Declares a state of emergency and activates the Missouri State Emergency Operations Plan in response to severe weather that began on April 10, 2013.	April 10, 2013	38 MoReg 753
13-05	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to severe weather that began on Feb. 20, 2013.	Feb. 21, 2013	38 MoReg 505
13-04	Expresses the commitment of the state of Missouri to the establishment of Western Governors University (WGU) as a non-profit institution of higher education located in Missouri that will provide enhanced access for Missourians to enroll in and complete on-line, competency-based higher education programs. Contemporaneously with this Executive Order, the state of Missouri is entering into a Memorandum of Understanding (MOU) with WGU to further memorialize and establish the partnership between the state of Missouri and WGU.	Feb. 15, 2013	38 MoReg 467
13-03	Orders the transfer of the Division of Energy from the Missouri Department of Natural Resources to the Missouri Department of Economic Development.	Feb. 4, 2013	38 MoReg 465
13-02	Orders the transfer of the post-issuance compliance functions for tax credit and job incentive programs from the Missouri Department of Economic Development to the Missouri Department of Revenue.	Feb. 4, 2013	38 MoReg 463
13-01	Orders the transfer of the Center for Emergency Response and Terrorism from the Department of Health and Senior Services to the Department of Public Safety.	Feb. 4, 2013	38 MoReg 461

The rule number and the MoReg publication date follow each entry to this index.

ACCOUNTANCY, MISSOURI STATE BOARD OF
fees; 20 CSR 2010-2.160; 7/15/13, 11/1/13

ADMINISTRATION, OFFICE OF
commissioner of administration
Missouri accountability portal; 1 CSR 10-7.010; 11/1/13
personnel advisory board and division of personnel
definitions of terms; 1 CSR 20-5.015; 10/15/13
leaves of absence; 1 CSR 20-5.020; 10/15/13
state official's salary compensation schedule; 1 CSR 10; 12/2/13

AGRICULTURE
animal health
inspection of meat and poultry; 2 CSR 30-10.010; 1/2/14
movement of livestock, poultry, and exotic animals within Missouri; 2 CSR 30-2.020; 9/3/13
state milk board
inspection fees; 2 CSR 80-5.010; 9/3/13
inspection frequency and procedure; 2 CSR 80-2.050; 9/3/13
weights and measures
quality standards for motor fuels; 2 CSR 90-30.040; 7/1/13

AIR QUALITY, AIR POLLUTION CONTROL
additional air quality control measures may be required when sources are clustered in a small land area; 10 CSR 10-5.240; 11/15/13
ambiant air quality standards; 10 CSR 10-6.010; 12/16/13
auto exhaust emission control; 10 CSR 10-3.010; 7/1/13, 12/2/13
commercial and industrial solid waste incinerators; 10 CSR 10-6.161; 8/15/13
controlling emissions during episodes of high air pollution potential; 10 CSR 10-6.130; 6/17/13, 11/1/13
definitions and common reference tables; 10 CSR 10-6.020; 8/15/13
emission standards for hazardous air pollutants; 10 CSR 10-6.080; 6/17/13, 11/1/13
hospital, medical, infection waste incinerators; 10 CSR 10-6.200; 9/3/13, 12/2/13
maximum achievable control technology regulations; 10 CSR 10-6.075; 6/17/13, 11/1/13
new source performance regulations; 10 CSR 10-6.070; 6/17/13, 11/1/13

ARCHITECTS, PROFESSIONAL ENGINEERS. PROFESSIONAL LAND SURVEYORS, AND LANDSCAPE ARCHITECTS, MISSOURI BOARD FOR
guidelines for acceptable standard of care; 20 CSR 2030-2.060; 9/16/13
standard of care when evaluating criteria for building design; 20 CSR 2030-2.040; 9/16/13
title block; 20 CSR 2030-2.050; 9/16/13

BEHAVIOR ANALYST ADVISORY BOARD
ethical rules of conduct; 20 CSR 2063-6.005; 10/15/13

BREATH ALCOHOL IGNITION INTERLOCK DEVICE CERTIFICATION AND OPERATIONAL REQUIREMENTS
approval procedure; 7 CSR 60-2.020; 4/15/13
breath alcohol ignition interlock device security; 7 CSR 60-2.050; 4/15/13
definitions; 7 CSR 60-2.010; 4/15/13
responsibilities of authorized service providers; 7 CSR 60-2.040; 4/15/13
standards and specifications; 7 CSR 60-2.030; 4/15/13
suspension or revocation of approval of a device; 7 CSR 60-2.060; 4/15/13

BUSINESS AND COMMUNITY SERVICES, DIVISION OF
application process; 4 CSR 85-9.020; 12/2/13
definitions
4 CSR 85-8.010; 12/2/13
4 CSR 85-9.010; 12/2/13
event notification; 4 CSR 85-9.040; 12/2/13
final application; 4 CSR 85-9.050; 12/2/13
project proposal; 4 CSR 85-9.030; 12/2/13
program administration; 4 CSR 85-8.020; 12/2/13
tax credit accountability act compliance; 4 CSR 85-8.030; 12/2/13

CERTIFICATE OF NEED PROGRAM
application review schedule; 19 CSR 60-50; 11/1/13, 12/2/13, 1/2/14

CHILDREN'S DIVISION
alternative care review board; 13 CSR 35-36.010; 12/2/13
hand-up pilot program; 13 CSR 35-32.040; 6/3/13, 10/1/13

CLEAN WATER COMMISSION
effluent regulations; 10 CSR 20-7.015; 6/17/13
fees; 10 CSR 20-6.011; 10/1/13
water quality standards; 10 CSR 20-7.031; 6/17/13

CONSERVATION, DEPARTMENT OF
bullfrogs and green frogs; 3 CSR 10-12.115; 11/1/13
channel catfish, blue catfish, flathead catfish; 3 CSR 10-6.510; 3 CSR 10-6.510; 11/1/13
commercial deer processing: permit, privileges, requirements; 3 CSR 10-10.744; 11/1/13
commercialization; 3 CSR 10-10.705; 11/1/13
deer
firearms hunting season; 3 CSR 10-7.433; 11/1/13
hunting seasons; general provisions; 3 CSR 10-7.431; 11/1/13
dove hunting; 3 CSR 10-11.185; 11/1/13
falconry; 3 CSR 10-9.442; 11/1/13
fishing
daily and possession limits; 3 CSR 10-12.140; 11/1/13
length limits; 3 CSR 10-12.145; 11/1/13
methods; 3 CSR 10-12.135; 11/1/13
methods and hours; 3 CSR 10-11.205; 11/1/13
general prohibition: applications; 3 CSR 10-9.110; 11/1/13
general provisions; 3 CSR 10-9.105; 11/1/13
hunting
and trapping; 3 CSR 10-12.125; 11/1/13
general provisions and seasons; 3 CSR 10-11.180; 11/1/13
methods; 3 CSR 10-7.410; 11/1/13
migratory game birds and waterfowl; seasons, limits; 3 CSR 10-7.440; 11/1/13
monetary values established for fish and wildlife; 3 CSR 10-3.010; 11/1/13
other fish; 3 CSR 10-6.550; 11/1/13
owner may protect property; public safety; 3 CSR 10-4.130; 11/1/13
quail hunting; 3 CSR 10-11.184; 11/1/13
trout permit; 3 CSR 10-5.430; 11/1/13
use of boats and motors; 3 CSR 10-12.110; 11/1/13
vehicles, bicycles, horses, and horseback riding; 3 CSR 10-11.130; 11/1/13
white bass, yellow bass, striped bass; 3 CSR 10-6.545; 11/1/13

COSMETOLOGY AND BARBER EXAMINERS, BOARD OF
crossover schools; 20 CSR 2085-13.070; 10/15/13
general rules and application requirements for all schools; 20 CSR 2085-12.010; 10/15/13
instructor renewal and inactive license requirements; 20 CSR 2085-8.070; 1/2/14
specific requirements for barber schools; 20 CSR 2085-12.020; 10/15/13

ELECTIONS
initiative, referendum, new party and independent candidate petitions Missouri Voter Registration System option; 15 CSR 30-15.030; 9/16/13, 1/2/14
processing procedures for initiative, referendum, new party and independent candidate petitions; 15 CSR 30-15.020; 10/1/13
signature verification procedures for initiative, referendum, new party and independent petitions; 15 CSR 30-15.010; 10/1/13

ELEMENTARY AND SECONDARY EDUCATION, DEPARTMENT OF
application for certificate of license to teach; 5 CSR 20-400.500; 12/2/13
approval of eligible employees; 5 CSR 20-300.190; 10/1/13
certification requirements for teacher of
adult education and literacy; 5 CSR 20-400.700; 12/2/13
career continuous administrator certificate; 5 CSR 20-400.630; 12/2/13
career continuous career education certificate; 5 CSR 20-400.690; 12/2/13
career continuous student services certificate; 5 CSR 20-400.650; 12/2/13
career education (postsecondary) certificates; 5 CSR 20-400.670; 12/2/13
career education (secondary) certificates; 5 CSR 20-400.660; 12/2/13
career education (secondary/postsecondary) certificates; 5 CSR 20-400.680; 12/2/13
early childhood education (birth-pre-kindergarten); 5 CSR 20-400.510; 12/2/13
elementary education (grades K-6); 5 CSR 20-400.520; 12/2/13
English for speakers of other languages (grades K-12); 5 CSR 20-400.570; 12/2/13
gifted education (grades K-12); 5 CSR 20-400.580; 12/2/13
initial administrator certificate; 5 CSR 20-400.610; 12/2/13
initial student services certificate; 5 CSR 20-400.640; 12/2/13
K-12 education; 5 CSR 20-400.550; 12/2/13
mathematics specialists (grades 1-6); 5 CSR 20-400.590; 12/2/13
middle school education (grades 5-9); 5 CSR 20-400.530; 12/2/13
secondary education (grades 9-12); 5 CSR 20-400.540; 12/2/13
special education; 5 CSR 20-400.560; 12/2/13
special reading (grades K-12); 5 CSR 20-400.600; 12/2/13
transition administrator certificate; 5 CSR 20-400.620; 12/2/13
charter school closure; 5 CSR 20-100.265; 11/1/13
definitions; 5 CSR 20-500.120; 11/1/13
disbursement of funds; 5 CSR 20-300.200; 10/1/13
districts effectively evaluating educators; 5 CSR 20-400.375; 6/3/13, 12/2/13
eligibility for scholarships; 5 CSR 10-2.030; 12/2/13
establishment of sheltered workshops; 5 CSR 20-300.160; 10/1/13
general department organization; 5 CSR 10-1.010; 10/1/13
Missouri school improvement program; 5 CSR 20-100.170; 12/2/13
operation of extended employment sheltered workshops; 5 CSR 20-300.170; 10/1/13
physical fitness challenge/assessment "Cade's Law"; 5 CSR 20-200.290; 11/1/13
rebuild Missouri schools program; 5 CSR 30-640.100; 10/1/13
renewal or revocation of a certificate of authority; 5 CSR 20-300.180; 10/1/13
scholarship granting organizations; 5 CSR 10-2.010; 12/2/13
scholarships; 5 CSR 10-2.020; 12/2/13
training of school employees in the care needed for students with diabetes; 5 CSR 20-200.300; 11/1/13

ENERGY, DIVISION OF
definitions and general provisions; 10 CSR 140-5.010; 7/1/13, 10/15/13

EXAMINERS FOR HEARING INSTRUMENT SPECIALISTS, BOARD OF
fees; 20 CSR 2165-1.020; 10/15/13
licensure by examination; 20 CSR 2165-2.030; 10/15/13

EXECUTIVE ORDERS
advises that state offices will be closed on November 29, 2013; 13-13; 11/15/13
orders the Missouri Department of Revenue to follow sections 143.031.1 and 143.091, RSMo, and require all taxpayers who properly file a joint federal income tax return to file a combined state income tax return; 13-14; 12/16/13

FAMILY SUPPORT DIVISION
child support program, general administration
state directory of new hires; 13 CSR 40-100.040; 10/15/13
community programs
formula for the distribution of community service block grant funds to community action agencies; 13 CSR 40-24.080; 12/2/13
supplemental funding formula for community action agencies to administer the CSBG program; 13 CSR 40-24.090; 12/2/13
use of community service block grant discretionary funds; 13 CSR 40-24.100; 12/2/13
family healthcare
application procedure for family MO HealthNet programs and Children's Health Insurance program (CHIP); 13 CSR 40-7.015; 9/3/13, 1/2/14
calculation of modified adjusted gross income (MAGI); 13 CSR 40-7.030; 9/3/13, 1/2/14
household composition; 13 CSR 40-7.020; 9/3/13, 1/2/14
scope and definition; 13 CSR 40-7.010; 9/3/13, 1/2/14
verification procedures; 13 CSR 40-7.040; 9/3/13, 1/2/14
income maintenance
general application procedures; 13 CSR 40-2.010; 9/3/13, 1/2/14

FINANCE, DIVISION OF
operations and supervision of residential mortgage loan brokers; 20 CSR 1140-30.240; 10/15/13

GAMING COMMISSION, MISSOURI
minimum internal control standards (MICS)
chapter F; 11 CSR 45-9.106; 6/3/13, 11/1/13
chapter J; 11 CSR 45-9.110; 6/3/13, 11/1/13
chapter K; 11 CSR 45-9.111; 12/2/13
chapter R; 11 CSR 45-9.118; 6/3/13, 11/1/13
chapter S; 11 CSR 45-9.119; 12/2/13
shipping of electronic gaming devices, gaming equipment, or supplies; 11 CSR 45-5.237; 12/2/13

GEOLOGIST REGISTRATION, MISSOURI BOARD OF
educational requirements; 20 CSR 2145-2.020; 7/1/13, 12/2/13
fees; 20 CSR 2145-1.040; 7/1/13, 12/2/13
post-baccalaureate experience in geology; 20 CSR 2145-2.030; 7/1/13, 12/2/13

renewal of license; 20 CSR 2145-2.080; 7/1/13, 12/2/13
temporary courtesy license; 20 CSR 2145-2.065; 7/1/13, 12/2/13

GEOLOGY AND LAND SURVEY, DIVISION OF
heat pump
certification and registration of heat pump systems; 10 CSR 23-5.020; 7/1/13, 11/15/13
closed-loop heat pump systems that use refrigerants as the heat transfer fluid; 10 CSR 23-5.070; 7/1/13, 11/15/13
construction standards for
closed-loop heat pump wells; 10 CSR 23-5.050; 7/1/13, 11/15/13
open-loop heat pump systems that use groundwater; 10 CSR 23-5.060; 7/1/13, 11/15/13
definitions; 10 CSR 23-5.010; 7/1/13, 11/15/13
general protection of groundwater quality and resources; 10 CSR 23-5.030; 7/1/13, 11/15/13
location of heat pump wells; 10 CSR 23-5.040; 7/1/13, 11/15/13
plugging of heat pump wells; 10 CSR 23-5.080; 7/1/13, 11/15/13

HEALTH AND SENIOR SERVICES
regulation and licensure
environmental waste management and support services; 19 CSR 30-20.114; 7/15/13, 12/16/13
home-care services in hospitals; 19 CSR 30-20.122; 7/15/13, 12/16/13
medical services; 19 CSR 30-20.124; 7/15/13, 12/16/13
orientation and continuing education; 19 CSR 30-20.110; 7/15/13, 12/16/13
outpatient services in hospitals; 19 CSR 30-20.118; 7/15/13, 12/16/13
pathology and medical laboratory services; 19 CSR 30-20.098; 7/15/13, 12/16/13
quality assessment and performance improvement program; 19 CSR 30-20.112; 7/15/13, 12/16/13
variance requests; 19 CSR 30-20.142; 7/15/13, 12/16/13
state public health laboratory
approved breath analyzers; 19 CSR 25-30.050; 10/15/13
breath analyzer calibration and accuracy verification standards; 19 CSR 25-30.051; 10/15/13
operating procedures for breath analyzers; 19 CSR 25-30.060; 10/15/13
type II permit; 19 CSR 25-30.031; 10/15/13

HIGHWAYS AND TRANSPORTATION COMMISSION, MISSOURI
outdoor advertising
administrative review of notices to remove outdoor advertising and to terminate nonconforming signs; 7 CSR 10-6.090; 11/15/13
cutting and trimming of vegetation on right-of-way; 7 CSR 10-6.085; 11/15/13
definitions; 7 CSR 10-6.015; 11/15/13
directional and other official signs; 7 CSR 10-6.020; 11/15/13
nonconforming signs; 7 CSR 10-6.060; 11/15/13
on-premises signs; 7 CSR 10-6.030; 11/15/13
outdoor advertising
beyond six hundred sixty feet of the right-of-way; 7 CSR 10-6.050; 11/15/13
in zoned and unzoned commercial and industrial areas; 7 CSR 10-6.040; 11/15/13
permits for outdoor advertising; 7 CSR 10-6.070; 11/15/13
public information; 7 CSR 10-6.010; 11/15/13
removal of outdoor advertising without compensation; 7 CSR 10-6.080; 11/15/13

INSURANCE
applied behavior analysis maximum benefit; 20 CSR; 3/1/13
construction claims binding arbitration cap; 20 CSR; 1/2/14
continuing education for individual navigators; 20 CSR 400-11.120; 11/1/13
credit for reinsurance; 20 CSR 200-2.100; 11/1/13
mental health services allowed out-of-network; 20 CSR 400-2.160; 10/1/13
Missouri health insurance pool transitional plan of operations; 20 CSR 400-12.100; 11/1/13
Missouri life and health insurance guaranty association; 20 CSR 400-5.600; 11/15/13
navigator examination and licensing procedures and standards; 20 CSR 400-11.100; 9/3/13, 12/16/13
sovereign immunity limits; 20 CSR; 1/2/14
state legal expense fund; 20 CSR; 1/2/14

INTERPRETERS, STATE COMMITTEE OF
application for licensure; 20 CSR 2232-2.010; 9/3/13, 12/16/13
application for temporary licensure; 20 CSR 2232-2.020; 9/3/13, 12/16/13
fees; 20 CSR 2232-1.040; 9/3/13, 12/16/13
name and address change, license renewal, and inactive license; 20 CSR 2232-2.030; 9/3/13, 12/16/13

LABOR AND INDUSTRIAL RELATIONS, DEPARTMENT OF
employment security
appeals to an appeals tribunal; 8 CSR 10-5.010; 7/1/13, 10/15/13
charging of benefits to reimbursable employers; 8 CSR 10-3.085; 11/15/13
fraud penalties on federal and state benefits; 8 CSR 10-3.150; 10/1/13
prohibition on the non-charging of benefits; 8 CSR 10-4.210; 10/1/13
records and reports; 8 CSR 10-4.020; 10/1/13
workers' compensation
resolution of medical fee disputes; 8 CSR 50-2.030; 12/16/13

LAND RECLAMATION COMMISSION
penalty assessment; 10 CSR 40-8.040; 8/15/13, 12/2/13
permanent program inspection and enforcement; 10 CSR 40-8.030; 8/15/13, 12/2/13
review, public participation, and approval of permit applications and permit terms and conditions; 10 CSR 40-6.070; 8/15/13, 12/2/13
surface mining permit applications–minimum requirements for legal, financial, compliance, and related information; 10 CSR 40-6.030; 8/15/13, 12/2/13
underground mining permit applications–minimum requirements for legal, financial, compliance, and related information; 10 CSR 40-6.100; 8/15/13, 12/2/13

MISSOURI CONSOLIDATED HEALTH CARE PLAN
additional plan options
22 CSR 10-2.130; 9/3/13, 12/16/13
22 CSR 10-3.130; 9/3/13, 12/16/13
contributions; 22 CSR 10-2.030; 1/2/14
coordination of benefits; 22 CSR 10-2.070; 1/2/14
definitions
22 CSR 10-2.010; 1/2/14
22 CSR 10-3.010; 1/2/14
general foster parent membership provisions; 22 CSR 10-2.110; 1/2/14
general membership provisions
22 CSR 10-2.020; 1/2/14
22 CSR 10-3.020; 1/2/14

general organization; 22 CSR 10-1.010; 1/2/14
limitations
PPO 300 plan, PPO 600 plan, and HDHP; 22 CSR 10-2.060; 1/2/14
PPO 600 Plan, PPO 1000 Plan, and HDHP; 22 CSR 10-3.060; 1/2/14
pharmacy benefit summary
22 CSR 10-2.090; 1/2/14
22 CSR 10-3.090; 1/2/14
pharmacy employer group waiver plan for medicare primary members; 22 CSR 10-2.089; 1/2/14
plan benefit provisions and covered charges
high deductible health plan
22 CSR 10-2.053; 1/2/14
22 CSR 10-3.055; 1/2/14
medicare supplement; 22 CSR 10-2.054; 1/2/14
medical
22 CSR 10-2.055; 1/2/14
22 CSR 10-3.057; 1/2/14
PPO 300; 22 CSR 10-2.051; 1/2/14
PPO 600
22 CSR 10-2.052; 1/2/14
22 CSR 10-3.056; 1/2/14
PPO 1000; 22 CSR 10-3.053; 1/2/14
PPO 2000; 22 CSR 10-3.054; 1/2/14
plan utilization review policy
22 CSR 10-2.045; 1/2/14
22 CSR 10-3.045; 1/2/14
public records; 22 CSR 10-1.020; 1/2/14
review and appeals procedure
22 CSR 10-2.075; 1/2/14
22 CSR 10-3.075; 1/2/14
tobacco-free incentive provisions and limitations; 22 CSR 10-2.094; 10/1/13
wellness center provisions, charges, and services; 22 CSR 10-2.140; 1/2/14
wellness program; 22 CSR 10-2.120; 10/1/13

MO HEALTHNET
ambulance service reimbursement allowance; 13 CSR 70-3.200; 11/15/13
behavioral health services program documentation; 13 CSR 70-98.015; 11/1/13
department is the payer of last resort, department's lien for recovery, participant's duty of cooperation; 13 CSR 70-4.120; 11/1/13
drug prior authorization process; 13 CSR 70-20.200; 11/1/13
durable medical equipment program; 13 CSR 70-60.010; 11/1/13
federal reimbursement allowance (FRA); 13 CSR 70-15.110; 8/1/13, 12/2/13
global per diem adjustments to nursing facility and HIV nursing facility reimbursement rates; 13 CSR 70-10.016; 12/2/13
hearing aid program; 13 CSR 70-45.010; 11/15/13
hospice services program; 13 CSR 70-50.010; 11/1/13
inpatient hospital services reimbursement plan; outpatient hospital services reimbursement methodology; 13 CSR 70-15.010; 8/1/13, 12/2/13
limitations on payment for inpatient hospital care; 13 CSR 70-15.030; 10/15/13
list of excludable drugs
excluded from coverage under the MO HealthNet pharmacy program; 13 CSR 70-20.032; 10/15/13
for which prior authorization is required; 13 CSR 70-20.031; 10/15/13
MO HealthNet (Medicaid) payment for certain services furnished by certain physicians in calendar years 2013 and 2014; 13 CSR 70-25.120; 11/15/13
multiple source drugs for which there exists a federal upper limit on reimbursement; 13 CSR 70-20.071; 11/1/13
optical benefits and limitations–MO HealthNet Program; 13 CSR 70-40.010; 11/15/13
prior authorization of new drug entities or new drug dosage form; 13 CSR 70-20.250; 10/15/13
prior authorization process for non-pharmaceutical behavioral health services; 13 CSR 70-98.020; 11/15/13
professional dispensing fee; 13 CSR 70-20.060; 11/1/13
prospective drug use review process and patient counseling; 13 CSR 70-20.310; 10/15/13
prospective outpatient hospital services reimbursement methodology; 13 CSR 70-15.160; 8/1/13, 12/2/13
prospective reimbursement plan for nursing facility services; 13 CSR 70-10.015; 8/1/13, 12/2/13
public/private long-term care services and supports partnership supplemental payment to nursing facilities; 13 CSR 70-10.160; 8/1/13, 10/1/13, 12/2/13
retrospective drug use review process; 13 CSR 70-20.300; 10/15/13
return of drugs; 13 CSR 70-20.050; 10/15/13
sanctions for false or fraudulent claims for MO HealthNet services; 13 CSR 70-3.030; 10/15/13
therapy program; 13 CSR 70-70.010; 11/1/13

MOTOR CARRIER AND RAILROAD SAFETY
application for a self-insurer status; 7 CSR 265-10.035; 6/17/13, 11/15/13
application requirements for the issuance and transfer of intrastate motor carrier authority; 7 CSR 265-10.015; 6/17/13, 11/15/13
classification of common carriers by services performed; 7 CSR 265-10.070; 6/17/13, 11/15/13
complaints; 7 CSR 265-10.130; 6/17/13, 11/15/13
definitions; 7 CSR 265-10.010; 6/17/13, 11/15/13
discontinuance of service; suspension and revocation of certificates, permits, and property carrier registrations; 7 CSR 265-10.140; 6/17/13, 11/15/13
household goods tariffs; 7 CSR 265-10.120; 6/17/13, 11/15/13
inspection of books, records, property, equipment, and roadside stops by division personnel; 7 CSR 265-10.060; 6/17/13, 11/15/13
insurance; 7 CSR 265-10.030; 6/17/13, 11/15/13
joint service and interlining by passenger or household goods carriers; 7 CSR 265-10.110; 6/17/13, 11/15/13
licensing of vehicles; 7 CSR 265-10.020; 6/17/13, 11/15/13
marking of vehicles; 7 CSR 265-10.025; 6/17/13, 11/15/13
merger of duplicated or overlapping motor carrier operating authority; 7 CSR 265-10.090; 6/17/13, 11/15/13
motor vehicle leasing; 7 CSR 265-10.040; 6/17/13, 11/15/13
passenger service requirement; 7 CSR 265-10.045; 6/17/13, 11/15/13
passenger tariffs; 7 CSR 265-10.055; 6/17/13, 11/15/13
regulation of advertising by motor carriers; 7 CSR 265-10.100; 6/17/13, 11/15/13
rules governing the transportation of household goods; 7 CSR 265-10.080; 6/17/13, 11/15/13
tariffs, time schedules, and motor carrier documentation; 7 CSR 265-10.050; 6/17/13, 11/15/13

MOTOR CARRIERS
application for a self-insurer status; 4 CSR 265-2.068; 6/17/13, 11/15/13

discontinuance of service; suspension and revocation of certificates, and permits; 4 CSR 265-2.180; 6/17/13, 11/15/13
merger of duplicated or overlapping motor carrier operating authority; 4 CSR 265-2.190; 6/17/13, 11/15/13
passenger tariffs; 4 CSR 265-6.010; 6/17/13, 11/15/13
uniform system of account for Class I motor carriers of passengers; 4 CSR 265-12.030; 6/17/13, 11/15/13
uniform systems of accounts for Class B motor carriers of household goods and passengers; 4 CSR 265-12.020; 6/17/13, 11/15/13

MOTOR VEHICLE
optional second plate for commercial motor vehicles; 12 CSR 10-23.500; 10/1/13, 1/2/14

NURSING, STATE BOARD OF
general organization; 20 CSR 2200-1.010; 10/15/13
public complaint handling and disposition procedure; 20 CSR 2200-4.030; 10/1/13
requirements for licensure; 20 CSR 2200-4.020; 10/15/13

OCCUPATIONAL THERAPY, MISSOURI BOARD OF
application for limited permit; 20 CSR 2205-3.030; 8/15/13, 12/2/13

OPTOMETRY, STATE BOARD OF
license renewal; 20 CSR 2210-2.030; 1/2/14

PEACE OFFICER STANDARDS AND TRAINING PROGRAM
minimum continuing education training standards for school protection officers; 11 CSR 75-17.040; 10/1/13, 1/2/14
minimum training standards for school protection officers; 11 CSR 75-17.030; 10/1/13, 1/2/14
minimum training standards for school protection officer training centers; 11 CSR 75-17.010; 10/1/13, 1/2/14
minimum training standards for school protection officer training instructors; 11 CSR 75-17.020; 10/1/13, 1/2/14

PETROLEUM AND HAZARDOUS SUBSTANCE STORAGE TANKS
assessing the site at closure or change in service; 10 CSR 26-2.062; 7/15/13, 1/2/14
corrective action plan; 10 CSR 26-2.082; 7/15/13, 1/2/14
investigations for soil and groundwater cleanup; 10 CSR 26-2.078; 7/15/13, 1/2/14

PHARMACY, STATE BOARD OF
automated filling systems; 20 CSR 2220-2.950; 8/1/13, 12/2/13

PRIVATE INVESTIGATOR AND PRIVATE FIRE INVESTIGATOR EXAMINERS, BOARD OF
application for licensure
agency; 20 CSR 2234-3.010; 10/15/13
agency employee; 20 CSR 2234-3.040; 10/15/13
private fire investigator; 20 CSR 2234-2.015; 10/15/13
private investigator; 20 CSR 2234-2.010; 10/15/13
change of name, ownership, location, or investigator-in-charge; 20 CSR 2234-3.020; 10/15/13
code of conduct; 20 CSR 2234-7.010; 10/15/13
complaint handling and disposition; 20 CSR 2234-1.040; 10/15/13
continuing education; 20 CSR 2234-6.010; 10/15/13
definitions; 20 CSR 2234-1.010; 10/15/13
fees; 20 CSR 2234-1.050; 10/15/13
general organization; 20 CSR 2234-1.020; 10/15/13
licensure renewal
20 CSR 2234-2.040; 10/15/13
20 CSR 2234-3.030; 10/15/13
licensed agency investigator employees and agency fire investigator employees; 20 CSR 2234-3.070; 10/15/13
name and address changes; 20 CSR 2234-2.020; 10/15/13
policy for release of public records; 20 CSR 2234-1.030; 10/15/13
private investigator trainee
application for license; 20 CSR 2234-4.010; 10/15/13
licensure renewal; 20 CSR 2234-4.050; 10/15/13
name and address changes; 20 CSR 2234-4.030; 10/15/13
replacement of renewal license; 20 CSR 2234-4.040; 10/15/13
trainer responsibilities; 20 CSR 2234-4.020; 10/15/13
replacement of renewal license; 20 CSR 2234-2.030; 10/15/13

PROBATION AND PAROLE, STATE BOARD OF
definitions for intervention fees; 14 CSR 80-5.010; 12/2/13
intervention fee procedure; 14 CSR 80-5.020; 12/2/13

PROFESSIONAL REGISTRATION, DIVISION OF
designation of license renewal dates and related renewal information; 20 CSR 2231-2.010; 10/15/13

PSYCHOLOGISTS, STATE COMMITTEE OF
application for
licensure; 20 CSR 2235-1.030; 7/15/13, 12/2/13
provisional licensure; 20 CSR 2235-1.025; 7/15/13, 12/2/13
temporary licensure; 20 CSR 2235-1.026; 7/15/13, 12/2/13
fees; 20 CSR 2235-1.020; 7/15/13, 12/2/13
licensure by
endorsement of written EPPP examination score; 20 CSR 2235-2.065; 7/15/13, 12/2/13
examination; 20 CSR 2235-2.060; 7/15/13, 12/2/13

PUBLIC SAFETY, DEPARTMENT OF
director, office of
approval of accrediting organizations for crime laboratories; 11 CSR 30-14.010; 2/1/13, 9/16/13, 1/2/14
format for concealed carry permits; 11 CSR 30-15.010; 9/3/13, 1/2/14

PUBLIC SERVICE COMMISSION
filing and reporting requirements
requirements for carrier designation as eligible telecommunications carriers; 4 CSR 240-3.570; 9/16/13
manufactured home installers
definitions; 4 CSR 240-125.010; 9/16/13
installation decals; 4 CSR 240-125.070; 9/16/13
manufactured home installer license; 4 CSR 240-125.040; 9/16/13
modular units
modular unit dealer/selling agent setup responsibilities; 4 CSR 240-123.065; 9/16/13
monthly report requirement for registered modular unit dealers; 4 CSR 240-123.070; 9/16/13
re-inspection fee; 4 CSR 240-123.095; 9/16/13
new manufactured homes
manufactured home dealer setup responsibilities; 4 CSR 240-120.065; 9/16/13
monthly report requirement for registered manufactured home dealers; 4 CSR 240-120.130; 9/16/13
re-inspection fee; 4 CSR 240-120.085; 9/16/13
safety standards
safety standards for electrical corporations, telecommunications companies and rural electric cooperatives; 4 CSR 240-18.010; 9/3/13, 1/2/14
service and billing practices for residential customers of electric, gas, sewer, and water utilities
billing adjustments; 4 CSR 240-13.025; 9/3/13
billing and payment standards; 4 CSR 240-13.020; 9/3/13

cold weather maintenance of service: provision of residential heat-related utility service during cold weather; 4 CSR 240-13.055; 9/3/13
commission complaint procedures; 4 CSR 240-13.070; 9/3/13
definitions; 4 CSR 240-13.015; 9/3/13
denial of service; 4 CSR 240-13.035; 9/3/13
deposits and guarantees of payment; 4 CSR 240-13.030; 9/3/13
discontinuance of service; 4 CSR 240-13.050; 9/3/13
disputes; 4 CSR 240-13.045; 9/3/13
general provisions; 4 CSR 240-13.010; 9/3/13
inquiries; 4 CSR 240-13.040; 9/3/13
settlement agreement and payment agreement; 4 CSR 240-13.060; 9/3/13
universal service
applications for MoUSF funds; 4 CSR 240-31.080; 9/16/13
collection of MoUSF surcharge from end-user subscribers; 4 CSR 240-31.065; 9/16/13
definitions; 4 CSR 240-31.010; 9/16/13
disbursements of MoUSF funds; 4 CSR 240-31.090; 9/16/13
eligibility for funding
low-income customers and disabled customers; 4 CSR 240-31.050; 9/16/13
high cost areas; 4 CSR 240-31.040; 9/16/13
eligible telecommunications carrier requirements; 4 CSR 240-31.130; 9/16/13
lifeline program and disabled program; 4 CSR 240-31.120; 9/16/13
MoUSF assessment; 4 CSR 240-31.060; 9/16/13
MoUSFA; 4 CSR 240-31.030; 9/16/13
organization, powers, and meetings of the board; 4 CSR 240-31.020; 9/16/13
receipt of MoUSF funds; 4 CSR 240-31.070; 9/16/13
review of board and MoUSFA activities; 4 CSR 240-31.110; 9/16/13
review procedures for support payments; 4 CSR 240-31.100; 9/16/13
water utilities
environmental cost adjustment mechanism; 4 CSR 240-50.050; 9/16/13, 1/2/14

REAL ESTATE APPRAISERS
application for certification and licensure; 20 CSR 2245-3.010; 8/15/13, 12/2/13
case study courses; 20 CSR 2245-6.040; 8/15/13, 12/2/13
general organization; 20 CSR 2245-1.010; 8/15/13, 12/2/13
instructor approval; 20 CSR 2245-8.030; 8/15/13, 12/2/13
requirements; 20 CSR 2245-8.010; 8/15/13, 12/2/13
trainee real estate appraiser registration; 20 CSR 2245-3.005; 8/15/13, 12/2/13

RETIREMENT SYSTEMS
public school retirement system of Missouri, the
election to fill vacancy on board of trustees; 16 CSR 10-1.040; 8/1/13, 12/2/13
payment of funds to the retirement system; 16 CSR 10-3.010; 8/1/13, 12/2/13
requirements for membership; 16 CSR 10-4.005; 8/1/13, 12/2/13
service retirement
16 CSR 10-5.010; 8/1/13, 12/2/13
16 CSR 10-6.060; 8/1/13, 12/2/13
source of funds; 16 CSR 10-6.020; 8/1/13, 12/2/13

SECURITIES
application for registration; 15 CSR 30-52.015; 6/3/13
definitions; 15 CSR 30-50.010; 6/3/13
forms; 15 CSR 30-50.040; 6/3/13
general; 15 CSR 30-54.010; 6/3/13
NASAA statement of policy; 15 CSR 30-52.030; 6/3/13
not-for-profit securities; 15 CSR 30-54.070; 6/3/13
small company offering registration (formerly Missouri issuer registration); 15 CSR 30-52.275; 6/3/13
suggested form of investment letter; 15 CSR 30-54.150; 6/3/13

TAX
annual adjusted rate of interest; 12 CSR 10-41.010; 12/2/13
new apportionment method; 12 CSR 10-2.052; 11/1/13

TRAFFIC AND SAFETY DIVISION
approval procedures; 7 CSR 60-2.020; 10/15/13
breath alcohol ignition interlock device security; 7 CSR 60-2.050; 10/15/13
definitions; 7 CSR 60-2.010; 10/15/13
responsibilities of authorized service providers; 7 CSR 60-2.040; 10/15/13
standards and specifications; 7 CSR 60-2.030; 10/15/13
suspension, or revocation of approval of a device; 7 CSR 60-2.060; 10/15/13

UNIFORM COMMERCIAL CODE
definitions; 15 CSR 30-90.010; 10/1/13
refusal to file; cancellation; defects in filing; 15 CSR 30-90.090; 10/1/13
status of parties upon filing an information statement; 15 CSR 30-90.170; 10/1/13

VETERANS AFFAIRS
description of organization; 11 CSR 85-1.010; 7/15/13, 11/1/13
Missouri Veterans Homes program; 11 CSR 85-1.030; 7/15/13, 11/1/13
procedures for receiving information; 11 CSR 85-1.015; 7/15/13, 11/1/13
veterans services program; 11 CSR 85-1.020; 7/15/13, 11/1/13
Veterans Cemeteries Program; 11 CSR 85-1.050; 7/15/13, 11/1/13
Veterans Trust Fund; 11 CSR 85-1.040; 7/15/13, 11/1/13

To Subscribe to the *Missouri Register*

SALUS POPULI SUPREMA LEX ESTO
"The welfare of the people shall be the supreme law."

JASON KANDER
SECRETARY OF STATE

MISSOURI REGISTER

Contact us at: phone: (573) 751-4015 or email: rules@sos.mo.gov

ORDER FORM

☐ Enclosed is my check for $56 as payment in advance for one year of the ***Missouri Register***
Please start my subscription with the _____issue.

Please make checks payable to: **Secretary of State** or alternatively call us to charge your credit card.

Mail to: JASON KANDER
SECRETARY OF STATE
ADMINISTRATIVE RULES DIVISION
PO BOX 1767
JEFFERSON CITY, MO 65102

_____
Name or Firm (Please Type or Print) Attn:

_____
Address

_____
City State Zip Code

JASON KANDER
SECRETARY OF STATE
PO BOX 1767
JEFFERSON CITY, MO 65102

Periodical
Postage Paid at
Jefferson City,
MO

Non-Substantive Changes Form and Updated Transmittal Form Now Available Online

With SB 469 and HB 1135 having gone into effect on August 28, 2012, agencies may now file a request with the Joint Committee on Administrative Rules and the secretary of state concurrently to make non-substantive changes to rules in the *Code of State Regulations*. Non-substantive changes include changes in department or division name in response to statutory changes or executive orders, or changes in state agency address, state agency telephone numbers, email addresses, or state agency website addresses.

A form for Non-Substantive Changes may be found online at http://www.sos.mo.gov/adrules/forms.asp. Also available on the same page are other forms of the Administrative Rules Division of the Office of the Secretary of State including a new revised transmittal form.